November 6, 2013

Dear Reader,

Please find enclosed the most recent draft of Rhode Island's State Healthcare Innovation Plan. When the plan is finalized, it will be submitted to the federal Center for Medicare and Medicaid Innovation as the deliverable of the State Innovation Model (SIM) Design Program, known as Healthy Rhode Island. Moreover, the plan is meant to serve a roadmap for changing our state's health care system, moving away from unorganized care paid on a volume basis to a coordinated system supported by payment rooted in value.

The office of Lt. Governor, which has managed Healthy Rhode Island, invites comment on the draft plan.

The plan as presented is not complete. Actuarial analysis is currently underway and is expected to be completed and presented to the public the week of November 18. Methods for evaluation are dependent upon financial models, and are therefore not included in this draft. The plan does provide a review of the current health care system, a selection of reform efforts underway, a set of obstacles that the system faces in attaining cost containment and population health goals, and a set of proposed innovations to overcome those obstacles. These innovations are described at a high level, focusing on policy ideas and strategic impact. The innovations do not have, and are not meant to include, detailed program descriptions and implementation plans.

The comments that the state receives will impact the final plan. The state asks for specific comments on a number of innovations, though comments on all parts of the plan are welcomed and encouraged. The state intends, in the final draft, to provide greater linkages between reform efforts currently underway and the proposed innovations. Additionally, while the state would be unable to include every recommendation from the community in the final draft of the plan, the state intends to include all comments submitted on this draft as an appendix to the final plan.

Please submit comments to via e-mail to shipcomments@ltgov.state.ri.us or via mail to:
Office of Lt. Governor
State House Room 116
Providence, RI 02903
ATTN: Public Comments

The deadline for submitting comments is Tuesday, November 26 at 4:30pm. Comments are encouraged and welcomed before the deadline. Please contact the Office of Lt. Governor at (401) 222-2371 with any questions.

Thank you.

RHODE ISLAND STATE INNOVATION PLAN

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VISION STATEMENT AND GOALS

RHODE ISLAND'S STATE HEALTH CARE INNOVATION PLAN

Healthy Rhode Island aims to achieve measurable improvement in health and productivity of all Rhode Islanders, and achieve better care while decreasing the overall cost of care. We plan to transition from a disparate and health care provider and payer-centric environment to an organized delivery and payment system that is outcomes-oriented and person-centric.

The State of Rhode Island adopted the World Health Organization's definition of health which states, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Rhode Island seeks to ensure a sustainable system of supports and services to attain and promote health, as defined above, for all of its residents. In doing so, Rhode Island recognizes that payers and providers in the current health care system, as well as health related community-based organizations, are partners in reaching this new sustainable system.

The new sustainable system will support the health of Rhode Islanders, improve their experience and maintain a lower cost burden for them, government, employers and payers across the state. This will achieve the goals of the "Triple Aim," originally articulated by Donald Berwick, former Administrator of the Centers for Medicare and Medicaid Services (CMS)., and is the achievement of better health and better care at lower cost. (Institute for Healthcare Improvement, 2013)

Accordingly, the state and its partners will focus on improving population health through organized care delivery systems that focus on patient activation and care coordination across the health care continuum with attention to high quality at a lower cost. Inherent in this effort is strengthening the link between care delivery systems, the community, its policies and priorities, and the organizations that fulfill those priorities.

In order to achieve this holistic framework, the state believes it is necessary to encourage and support the organization of payers, physicians, hospitals and other healthcare providers into coordinated care teams using payment models supported by Centers for Medicare and Medicaid Services. These payment models may include pay-for-performance, bundled payments, shared savings [inclusive of Accountable Care Organizations (ACOs) and ACO-like structures] and other forms of shared financial responsibility. The payment structure supports the transition from fee-for-service to a value-based model of reimbursement intended to encourage a collaborative approach to provide efficient, high-quality and coordinated care to an attributed population of patients. As providers improve the health of their attributed population based on specified quality metrics and cost reduction they may be eligible to receive financial rewards or share in the savings with contracted payers.

The successful transition and implementation of these payment models will be contingent on the provision of necessary tools to the provider at the point of service including but not limited to technology, data and analytics, and collaborative team members. The magnitude of change that will

occur through a coordinated care model will require providers and payers to work together in new ways, deploying new tools and processes. Providers will need assistance to successfully accomplish in this new collaborative environment.

The new system must be built to support a sustainable economic model for consumers (including patients, employers, insurers and taxpayers) and for providers to enable the system's endurance. For that reason, efforts must be undertaken to address those areas of the system where a lack of coordination leads to unnecessary cost growth and, often, a poorer quality of care. These changes include improving care transitions and engaging patients that utilize the highest level of health resources. At the same time, investments in Rhode Island's future health must be made and preserved. Efforts to prevent disease or other conditions that detract from health should be considered part of the health system, despite their historical separation. These efforts include both traditional public health activities carried out by government as well as non-governmental organizations, and activities focused on building and maintaining health in communities.

The state sees the envisioned changes to the health system supported by six pillars – fundamental characteristics of the new value-based system. These pillars of the system are:

- Multi-payer – The new system of care must be adopted by a preponderance of payers in the state to ensure broad adoption of the new models.
- Payment Transformation – Systemic changes to how providers and provider organizations are paid are inherent in a move from fee-for-service to value-based payments methods.
- Patient/Consumer Centric – The new system must be realigned to support and engage patients and consumers as they maintain and improve health, and address injury and illness.
- Transparency – A system that is based on outcomes and total cost of care requires transparency across the system; specifically comparisons of outcome measures by provider and prices paid.
- Accountability – As the system moves away from fee-for-service, providers will become more accountable for the total cost of care, patient *and* population health outcomes. Additionally, the new system must be built upon the philosophy that patients, consumers, payers, and policy makers are all accountable for maintaining and improving the health of individuals across the state.
- Community Assets – Integrating the resources and assets that have a great impact on the health of Rhode Islanders, but were not historically considered part of the "health care system" will be a critical success factor in the new system.

Rhode Island's State Health Care Innovation Plan will identify where the current health care system supports or conflicts with these pillars and how proposed innovations build or bolster the pillars.

RHODE ISLAND AND ITS CURRENT HEALTHCARE SYSTEM

Rhode Island Demographics

Rhode Island, the nation's smallest state, has a population of approximately 1,050,292 (United States Census Bureau, 2013). The result of a population of such magnitude residing in a small geographic location is that the state is the second most densely populated with a density of approximately 1,005 people per square mile (WorldAtlas.Com, 2009). Currently, approximately 90.7% of Rhode Islanders can be considered as living in an urban area, compared to 80.7% as a national measure (State Health Access Data Assistance Center, 2012).

Approximately 76% of the state's residents are classified as white, non-Hispanic. The African-American population is 7.3%, the Hispanic population is 13.2% (United States Census Bureau, 2013). The Hispanic population has been growing at a very fast rate, increasing by almost 44% between the years 2000 and 2010 (Parker, 2013). Notably, there are health disparities between these groups, as discussed below.

Rhode Island has stood out in the past few years due to its unemployment rate; as this plan is being prepared in August, 2013, RI has the third highest rate in the nation and has been in the top five for at least four years. Rhode Island mirrors the national figures when it comes to poverty levels. For example, 22.9% of Rhode Islanders live below 138% of the poverty line, compared to 23.4% nationally (State Health Access Data Assistance Center, 2012).

The other demographic trend relevant to assessing population health is the percent of persons over the age of 65; standing at 14.4%, this proportion is higher than the national average of 13.1% (United States Census Bureau, 2013). Furthermore, according to the U.S Census figures in 2010, Rhode Island's percentage of seniors who are 85 and older is the highest in the nation at 17.61%. The Rhode Island Department of Administration's Division of Planning projected that 25% of the state's population will be 65 or older by 2040, and a significant portion of that will be over 85 (United States Census Bureau, 2013).

According to America's Health Rankings, there are disparities among different populations within the state. For example, a sedentary lifestyle is more prevalent among non-Hispanic blacks at 35.2 percent, than non-Hispanic whites at 23.3 percent. Obesity is more prevalent among non-Hispanic blacks at 35.7 percent than non-Hispanic whites at 24.7 percent and smoking is also more prevalent among non-Hispanic blacks at 15.4% than all Hispanics at 11.6% (United Health Foundation, 2012). According the Centers for Disease Control and Prevention, the national smoking rate for Hispanics is 12.9% (Centers for Disease Control and Prevention, 2013)

Insurance Coverage

The population of uninsured in Rhode Island (12.1%) is lower than the national average (15.8%). Rhode Island enjoys a relatively high rate of employer-sponsored insurance coverage at 60%, and also has a large share of its non-elderly population on Medicaid (20%) (Urban Institute, 2012). The forthcoming Medicaid expansion is expected to enroll an additional 38,000 Rhode Islanders (Center on Budget and

Policy Priorities, 2012), and an additional amount of the uninsured will receive coverage through purchasing insurance through the Exchange, HealthSourceRI, with coverage effective in 2014.

Current Healthcare System Model

The healthcare and social assistance sector in Rhode Island is large and vibrant, making up 20% percent of the Rhode Island employment market. (Rhode Island Department of Labor and Training, 2012). Below are the central healthcare organizations in the State and descriptions of some of the key relationships among them.

Insurance Market:

There are four companies in the private commercial market in Rhode Island: Blue Cross Blue Shield of Rhode Island (BCBSRI), United Healthcare, Tufts Health Plan and Neighborhood Health Plan of Rhode Island (NHPRI). Combined, they cover 556,903 lives as of December 2012, which represents a decline in number of commercially covered lives since 2011 (Office of the Health Insurance Commissioner of the State of Rhode Island, 2013). On average, since 2005, the enrollment in private market insurance has dropped 1.6% annually. This decline has been attributed to the lasting effects of the economic downturn and increase in the proportion of part-time or non-benefit jobs.

Most Rhode Islanders receive health insurance through their employers. Self-funded and fully insured large employer groups make up 84% of the total insured market (43% and 41% respectively.) Fully insured small group (13%) and fully insured individual subscribers (3%) are the remainder of the market (Office of the Health Insurance Commissioner of the State of Rhode Island, 2013).

Blue Cross Blue Shield of Rhode Island (BCBSRI) currently maintains the market majority of commercial lives at about 70% in the State. United Healthcare of New England has approximately 27 % of the market, and Tufts Health Plan has approximately 2.5% of the insured market (Office of the Health Insurance Commissioner of the State of Rhode Island, 2013).

Insurance Market Reforms

Since 2009, there has been a multi-payer effort to support the development of Patient Centered Medical Homes (PCMH's) through the Chronic Sustainability Initiative of Rhode Island (see below for further description). BCBRI, NHPRI and UHC have all been engaged in supporting this advance in the delivery of primary care.

In 2013, BCBSRI signed a contract with Rhode Island Primary Care Physicians Corporation to establish a Patient Centered Medical Home (PCMH) program or Medical Home. Through the program, BCBSRI pays physicians additional monthly fees to actively manage complex chronically ill patients; it has also invested in nurse managers on the primary care team. The goal of the project is to provide a better model of care focused on prevention and chronic care management and to improve health outcomes for patients. This effort has supported a number of Rhode Island primary care practices in the achievement of medical home development.

BCBSRI also partnered with South County Hospital to create a 'Medical Neighborhood' (Blue Cross and Blue Shield of Rhode Island, 2013). This model involves the participation of independently practicing physicians, but relies upon the hospital to be the central support staff that is typically found in a Medical Home. BCBSRI is also engaged with South County Hospital with a bundled payment model for orthopedics procedures (South County Hospital , 2013).

United Healthcare of New England announced, in February of 2013, that they were forming an "accountable coordinated care organization" (ACCO), which includes Lifespan's acute care hospitals and physicians who will provide coordinated care to approximately 21,000 people in the state that are enrolled in United Healthcare's employer-sponsored benefit plans. This model is focused on managing patients with chronic diseases, and paying participating providers incentives based on process and clinical outcome measures. (UnitedHealthCare, 2013)

United HealthCare currently acts as a third party administrator for the State of Rhode Island employee health insurance, a contract that expires at the end of 2013.

Neighborhood Health Plan of Rhode Island (NHPRI) is a locally based, not-for-profit health plan founded by the Community Health Centers of Rhode Island in 1993, in response to the initiation of RIte Care, the Rhode Island Medicaid managed care program. Using a network model, it offers coverage to four distinct Medicaid populations: families with low to moderate income, children with special healthcare needs, all children in the Rhode Island foster care system and Medicaid-only adults. At the end of 2013, it became the larger of two providers for the Integrated Care Initiative, which is a program designed to coordinate care for the Medicare and Medicaid dual eligible population. Currently, NHPRI covers approximately 66% of all Medicaid managed care recipients in Rhode Island and 50% of all Medicaid enrollees in Rhode Island. Over 90,000 individuals are enrolled in their programs. Starting in 2014, NHPRI will offer coverage in the individual and small employer market through HealthSourceRI, the state's health insurance exchange.

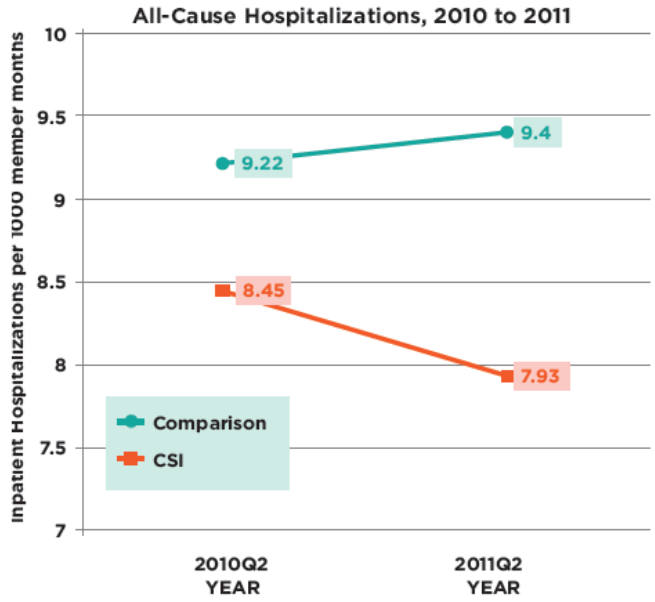
Tufts Health Plan has a small but growing presence in Rhode Island. They have been focusing on providing support to employers through the provision of robust wellness plans and are the only health plan in the Northeast to be awarded NCQA Wellness & Health Promotion Accreditation (Tufts Health Plan, 2013). They are considered leaders in the Massachusetts market and are expected to continue this work in Rhode Island when they offer plans on HealthSourceRI beginning in 2015.

Physicians and Physician Extenders:

According to a report completed by the Robert Graham Center in March of 2013 on behalf of the state's Health Care Planning and Accountability Advisory Council, there are approximately 841 primary care physicians in the state, a figure that includes family medicine, geriatricians, general practitioners, internal medicine practitioners and pediatricians (Robert Graham Center, 2013). According to the same study, these physicians account for approximately 32.8% of all medical providers, which is similar to the national figure of 33.3%

The Graham Center report also indicates that there are approximately 1,726 specialists in Rhode Island, accounting for 67.2% of the physician supply, which is similar to the national figure of 66.7%. Further, the Graham Center found that there are a total of 422 Nurse Practitioners and 277 Physician Assistants in the state. When the Graham Center looked at physician to population ratios, the Center found that Rhode Island ranks 8th in the nation for primary care and 6th in the nation for specialty care.

Some primary care physicians are organized into arrangements that promote the goals of the Triple Aim:



Source: CSI-RI Annual Report

Coastal Medical Practice – an ACO comprised entirely of physicians and supporting staff (101+ physicians, nurse practitioners and physician assistants). The organization began as a primary care practice but has expanded to include some specialties such as cardiology, pulmonary, pediatrics and infectious diseases. They have a patient panel of approximately 105,000 (a few are in Massachusetts) and some of their physicians are members of CSI-RI. In 2007, they made a strategic decision to start engaging in pay-for-performance contracts. In 2009, they put PCMH at the center of their strategy, focused on meaningful use and became involved with the state Beacon project (see below for more on Beacon). In 2011, they began to pursue shared savings arrangements with BCBSRI as well as United and Tufts. Currently, they are in the Medicare Shared Savings Program.

Rhode Island Primary Care Physicians Corporation (RIPCP) – An independent physicians association, the group represents over 150 physicians in the State. It contracts directly with both major insurance providers and supports its members' efforts to become recognized as National Committee on Quality Assurance (NCQA) PCMH's. RIPCP has more than 45 practices that have achieved a level 1 recognition for NCQA PCMH.

Most members of the Rhode Island healthcare community claim that a significant number of primary care physicians in the state belong to very small practices, or practice independently. According to the Graham Report, the median primary care practice size in Rhode Island is slightly smaller than other states (11 physicians compared to 12 nationally and 14 in other New England States). Approximately 27% of primary care physicians are in practices with 3 or fewer physicians (Robert Graham Center, 2013). These independent physicians represent a significant focus of the innovation efforts in the State.

Physician Organizations:

With a few exceptions, Rhode Island lacks the large multi-practice physician organizations that are seen in other parts of the country. The largest physician organizations in the state are the, Lifespan/Physician Services Organization with 800 physicians, the Women & Infants Physician-Hospital Organization (PHO) with 220 physicians, and the Providence and Kent PHO with 200 physicians. Coastal Medical is the largest primary care physician organization in the state with approximately 85 physicians. The Rhode Island Primary Care Physicians is an Independent Physician Association with approximately 163 independent primary care physicians. The rest of the physician groups are smaller or comprised of a single specialty, such as Rhode Island Medical Imaging, which is a group of fifty-three radiologists.

Hospital and Health Systems:

The environment is rapidly changing for the hospitals and health care systems in Rhode Island. There have been several recent purchases representing consolidation within the state, and another two pending purchases proposed by separate out-of-state for-profit systems for two hospitals; these pending purchases as of October, 2013 are in different stages of the review/approval process in the Department of Health and the Attorney General's office.

Hospital	Health System	City	Licensed inpatient capacity as of Sept 2012	Notes
Butler Hospital	Care New England	Providence	137	Psychiatric
Kent Hospital	Care New England	Warwick	262 plus 29 beds at Butler	
Women & Infants Hospital of RI	Care New England	Providence	167	Maternity, NICU
Memorial Hospital of Rhode Island	Under agreement to be purchased by Care New England	Pawtucket	147	Sale Pending
Roger Williams Medical Center	CharterCARE	Providence	126	Announced joint venture with Prospect Medical
Our Lady of Fatima Hospital	CharterCARE	North Providence	278	Announced join venture with Prospect Medical
The Westerly Hospital	Lawrence +Memorial of New London, CT	Westerly	64	
Rhode Island Hospital, Hasbro Children's Hospital	Lifespan	Providence	685	Level I Trauma
Newport Hospital	Lifespan	Newport	98	
The Miriam Hospital	Lifespan	Providence	247	

Emma Pendleton Bradley Hospital	Lifespan	Providence	60	Children's Psychiatric
Eleanor Slater Hospital	State-owned	Pascoag/Cranston campuses	495	Long term care only
Landmark Medical Center	Under agreement to be purchased by Prime Healthcare	Woonsocket	140	Approved by state regulators, Sale Pending
Providence VA Medical Center	Veteran's Administration	Providence	73*	
Rehabilitation Hospital	Under agreement to be purchased by Prime Healthcare	Woonsocket	40	

Source: The Lewin Group, 2013

Rhode Island has witnessed the development of hospital systems over the past few decades. In 2008, Landmark Hospital in Woonsocket entered receivership. At the time of this publishing, the hospital had cleared all regulatory hurdles to proceed with a purchase by Prime Medical Services, an 18 hospital for-profit chain based in California. This would make Landmark the first for-profit hospital in the state. In 2013, Westerly Hospital (in receivership since 2011) was purchased by Lawrence and Memorial of New London Connecticut, and Care New England announced its intention to purchase Memorial Hospital. In addition, Prospect Medical Holdings of California recently signed an intention to purchase the CharterCARE Hospital System. A 2012 study commissioned by Health Care Planning and Accountability Council (HCPAAC) showed that there is projected to be a surplus of hospital beds of between 100 and 200 beds, in the next several years (The Lewin Group, 2013). While the report did not specify geographically the bed supply and demand, the finding continues to inform public opinion that healthcare in Rhode Island needs a more focused planning effort.

Major Health Systems

Care New England and Lifespan account for approximately 80% of Rhode Island's hospital beds (American Hospital Directory, 2013). By focusing efforts with these two systems in particular, it is expected that the state's innovation plan can make great strides with few touch points.

Care New England: a non-profit organization comprised of Butler Hospital, Kent Hospital, and Women and Infants Hospital with an agreement to purchase Pawtucket Memorial Hospital.

Lifespan: a non-profit organization made up of five facilities: Rhode Island Hospital (681 bed, tertiary care hospital with a Level 1 trauma center), Hasbro Children's Hospital, The Miriam Hospital, Bradley Hospital (a children's psychiatric hospital) and Newport Hospital.

CharterCare: a non-profit organization comprised of Roger Williams Medical Center, Our Lady of Fatima Hospital and St. Joseph Health Services. Recently it was announced that Prospect Medical Holdings a for-profit hospital chain based in CA, has signed an asset purchase agreement with Chartercare. Regulatory review of the purchase had not begun as this report was prepared.

Other hospitals: Westerly Hospital, South County Hospital, Landmark Hospital, the Providence VA Medical Center and the Eleanor Slater Public Hospital (495 beds across two campuses).

Federally Qualified Health Centers:

Rhode Island has eight Federally Qualified Health Centers (FHQC's) that serve approximately 123,035 patients: 31% of these patients are currently uninsured and 42.6% are covered by Medicaid. East Bay Family Health, Thundermist Health Center of West Warwick, and WellOne Primary Medical and Dental Care are participating in CMS' FQHC Advanced Primary Care Practice Demonstration. This is a three year program that will show how the patient-centered medical home model can improve quality of care, to promote the Triple Aim.

FQHC's in Rhode Island

FQHC	City	Patients Served in 2012
Blackstone Valley Community Health Care	Pawtucket	10,000
Comprehensive Community Action, Inc	Cranston	15,441
East Bay Community Action Program	Newport	7,984*
Northwest Community Healthcare (WellOne)	Pascoag	13,330
The Providence Community Health Centers, Inc	Providence	35,000
Thundermist Health Center	Woonsocket, West Warwick and Wakefield	30,495*
Tri-town Economic Opportunity Committee	Johnston	18,000
Wood River Health Services, Inc	Hope Valley	7076

*2009 data; **2011 data

Behavioral Health Providers

There are 8 private, not-for-profit Community Mental Health Organizations in the State of Rhode Island, two psychiatric hospitals (Butler and Bradley respectively) and numerous providers in private practice. Collectively, the 8 Mental Health Organizations (and Butler Hospital) serve more than 70,000 Rhode Islanders per year, which is approximately equal to the 7.2% of Rhode Islanders that have serious mental illness (Substance Abuse and Mental Health Services Administration, 2011).

CMHO	City	Approximate # Clients Served Annually
East Bay Center, Inc	East Providence	3000+
Fellowship Health Resources, Inc	Lincoln	Information requested
Gateway Healthcare, Inc	Pawtucket (recently purchased by Lifespan)	15,000+
The Kent Center for Human & Organizational Development	Warwick	4,000+
Newport County Community Mental Health Center, Inc	Middletown	1814*
NRI Community Services, Inc	Woonsocket	3900
The Providence Center	Providence	12,123
Riverwood Mental Health Services	Warren	500

*FY2013

Long-Term Care:

There are 84 long term care facilities in Rhode Island. Most of them are independently owned and approximately 80.5% are for-profit. The remaining facilities are non-profit, including the state-run Veterans Home (Centers for Medicare and Medicaid Services, 2011). According to CMS, Rhode Island has one of the highest rates in the country of nursing home beds per thousand persons aged 65 or older (Centers for Medicare and Medicaid Services, 2011).

Carelink is an important entity in the long-term-care community. It is a non-profit management service organization that supports the business activities of three Adult Day Care services, three Home Health Care agencies, three independent living facilities, six Assisted Living Facilities, seven Nursing Homes and one hospice agency. Carelink serves as one of the two organizations chosen to manage the Integrated Care Initiative (described more fully below) for individuals dually eligible for Medicare and Medicaid. Carelink manages the PACE-RI program:

> *Program of All-Inclusive Care for the Elderly (PACE) Organization of Rhode Island:* Established in 2005, in Rhode Island, by Carelink, the PACE Organization of Rhode Island is a member of the National PACE Association, which includes 72 PACE programs in 30 states. This organization helps to support the frail elderly who have complex healthcare needs and a strong desire to remain living in the community. Funded as a capitated system through per-enrollee payments from Medicare and Medicaid, it is able to manage these funds and fully coordinate the healthcare needs of its enrollees. The entrance requirements are that a recipient is over the age of 55, certified by the state to require nursing home care, and live in an area that is served by a PACE program (nearly all of Rhode Island qualifies). The integrated care consists of healthcare providers and social service providers, and includes all necessary services such as transportation and homemaker services for each patient. All services must be deemed medically necessary.

Home Health Care Agencies:

There are 37 Home Health Agencies in the State of Rhode Island. Few of them are integrated with other healthcare entities, such as hospitals. These agencies will be important elements to the new value based care system because they will serve as partners to primary care providers, hospitals and long-term-care institutions and provide important services in aiding patients as they transition between institutions, or back into their homes. Home health care and hospice agencies are also important to providing high quality end of life care. These agencies are expected to face pressure to consolidate and partner with institutions in the future.

Community-Based Organizations:

A number of Community Based Organizations provide services that will be necessary in the new value-based healthcare system. Some of these organizations already are well versed in issues such as patient privacy and outcome data collection, and others provide relevant services but are not fully coordinated across all care settings. Several of the most active organizations to date are listed below:

YMCA: The YMCA of Greater Providence includes seven different branches across the state. The YMCA has a number of healthcare services, including "Join 4 Me," a program aimed at helping overweight children and teenagers achieve a healthy weight; a Diabetes Prevention Program, which is aimed at those with rising risk and is paid for by one commercial insurance carrier (UnitedHealthCare); and the Livestrong program which supports adult cancer survivors who have become deconditioned or chronically fatigued. There is a statewide alliance of YMCA's which is moving toward the creation of a statewide health resource.

Healthleads: This is a Providence chapter of a local organization that helps connect patients to the basic resources they need to be healthy, such as nutrition, housing or jobs. This chapter is based at Hasbro Hospital, and advocates work with both providers and patients to make them aware of the local resources available to patients. Providers write 'prescriptions' for needed community resources, and advocates then help patients get connected to those resources. Staffed by college students, the Healthleads program is one successful response to the awareness of the importance of paying attention to social determinants of health.

Community Action Rhode Island: There are nine Community Action Programs (CAP Agencies) that provide social service support for Rhode Island's poor. Many of these agencies provide services that both directly and indirectly support the health of their client base, such as case management services for elders and family members, lead poisoning case management, fall prevention programs for the elderly, housing assistance, heating assistance and an emergency food supply, to name but a few.

Rhode Island Parent Information Network: (RIPIN): RIPIN is an organization dedicated to empowering Rhode Islanders through information, support and training, and has a significant focus on healthcare. Among their recent programs are/were an intervention program designed at working with high ED utilizers on a case management basis, a pediatric practice enhancement

project and peer to peer resources to help individuals navigate health insurance information and enrollment.

Employers: Self-funded large employer groups make up 43% of the commercial insurance market (Office of the Health Insurance Commissioner of the State of Rhode Island, 2013)**.** Changes to the healthcare market in Rhode Island will need the support of this group of employers. According to the Graham Report referenced earlier, the top ten employers in 2010 in Rhode Island were private:

Employer	Number of Employees in Rhode Island
Rhode Island State Government	14,904
Lifespan	11,869
The United States Government	11,581
The Roman Catholic Dioceses of Providence	6,200
Care New England	5,953
CVS Corp	5,800
Citizens Financial Group (Royal Bank of Scotland)	5,800
Brown University	4,800
Stop and Shop Supermarket Co. (Royal Ahold)	3,632
Bank of America	3,500

Other Important Members of the Healthcare Community:

There are numerous community service programs in Rhode Island. Three major organizations that have a significant impact on care delivery in Rhode Island include the Rhode Island Quality Institute (RIQI) (RIQI) which is the state's not-for-profit designated entity for Health information exchange and serves as the State's regional Extension center and Healthcentric Advisors , the State's Quality Improvement Organization (QIO) which supports the provider community.

Rhode Island Quality Institute (RIQI): Founded in 2001, RIQI is a non-profit organization whose mission is to "significantly improve the quality, safety and value of health care in Rhode Island." Serving as a home for the Beacon Community Program, the Rhode Island Regional Extension Program, and Rhode Island's HIE, "CurrentCare," RIQI is dedicated to the development of quality health information that is available to patients, providers, payers and government. RIQI's Board of Directors is composed of representation from the rest of the local healthcare community, including hospitals, consumer groups, and academia.

Healthcentric Advisors: Incorporated in 1995, Healthcentric is a non-profit organization dedicated to helping healthcare providers improve the quality, value and safety of the care that they provide. Healthcentric supports local providers in quality improvement efforts, Electronic Health Records (EHR) implementation, and is currently home to the local Safe Transitions and Physician Resources for Quality initiatives.

Health-Related Agencies in the State of Rhode Island

There are a number of state agencies that work together to address the health needs of the residents of Rhode Island. The Executive Office of Health and Human Services houses the state's Medicaid program and provide fiscal and management oversight of four state departments including the Department of Health (RIDOH), Department of Human Services (DHS), the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) and the Department of Children, Youth and Families (DCYF). HealthSourceRI, is Rhode Island's state-based Health Insurance Exchange. The Office of the Health Insurance Commissioner (OHIC) is the regulatory agency overseeing all health insurance, including consumer and provider issues regarding insurance. Finally, the Lieutenant Governor's office has functioned as a key convener and leader of coordinated health care reform efforts. The work of other agencies, such as the Division of Planning within the Department of Administration, the Department of Transportation and the Department of Environmental Management also affects the health of Rhode Islanders. The Department of Administration also plays a key role in its management of state employees and retirees health benefits. The following is a summary of the key health-related roles and responsibilities of the five departments/offices listed above:

Agency/Office	Primary Responsibilities
Department of Health	Public health, licensing providers and facilities, Health Services Council, Inspections
Executive Office of Health and Human Services / Medicaid	Managing Medicaid policy and programs
Office of Health Insurance Commissioner	Regulating commercial health insurance
Department of Behavioral Health, Developmental Disabilities and Hospitals	State hospitals, Behavioral health and substance abuse programs and chronic long term medical and psychiatric conditions
HealthSourceRI	Health Insurance Exchange for individuals and small businesses

Healthcare Information and Technology in Rhode Island

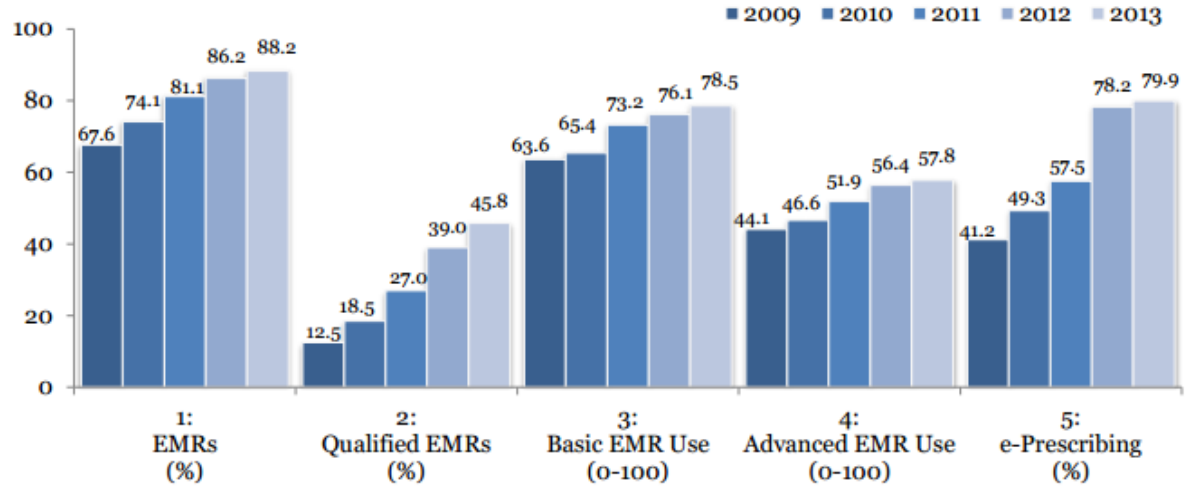
Rhode Island has been a leader in creating the information and technology backbone that will continue to support the State's transition to value-based care. The following section outlines the State's progress in Electronic Health Record (EHR) adoption, the Health Information Exchange (HIE) known as CurrentCare, KIDSNET, the state's integrated child health information system which includes the state's immunization registry (and functions like a public health information exchange for children), the All Payer Claims Database (APCD) and the Unified Health Infrastructure Project (UHIP).

Electronic Health Record (EHR) Adoption: Rhode Island is on track with or ahead of the rest of the country with regard to the Office of the National Coordinator for Health Information (ONC) reported EHR adoption rates as represented in the table below (Health IT Dashboard, 2013).

In early 2013, the Rhode Island Department of Health administered the HIT survey to 3,799 physicians licensed in Rhode Island, in active practice, and located in Rhode Island, Connecticut or Massachusetts. The response rate was 62.3% (n=2,367) (Rhode Island Department of Health, 2013).

The following table from the Department of Health shows current trends:

Figure 1: HIT Survey – Physicians, Results Trends among Survey Respondents, 2009-2013[i]



In 2010, Rhode Island received $11.28 million from the American Recovery and Reinvestment Act (ARRA) in the form of grants to the Rhode Island Quality Institute (RIQI) for investments in Health Information Technology. $6,000,000 went to the creation and funding of the Regional Extension Center (REC) designed to assist providers with EHR implementation and achieving Meaningful Use. RIQI is an independent, non-profit organization dedicated to improving health care for all Rhode Islanders. Through the REC, primary care providers receive technical assistance and expert advice to HER adoption and achieving Meaningful Use. RIQI has also leveraged the Regional extension center and its staff of relationship managers to educate recruit and train providers on the following HIT programs and services including:

- CurrentCare Services – The RI REC staff works closely with their HIE colleagues HIE staff to promote and recruit provider offices to engage in CurrentCare (including getting provider offices to enroll their patients in CurrentCare, sign up to providers to use the CurrentCare clinical viewer, obtain a direct messaging account and subscribe to the hospital alerts service.
- Direct – Direct messaging is secure email for transmitting patients' protected health information (PHI). It allows for provider-to-provider communication, enables providers to receive Hospital

Alerts when a patient is admitted to a hospital or emergency department and enables providers to send clinical care document summaries to CurrentCare for their enrolled patients

- EHR Adoption for PCPs and Specialists – RI REC provides assistance to eligible providers in selecting an EHR and achieving Meaningful Use
- EHR Integration – Becoming a data sharing partner by integrating EHR data with CurrentCare helps to improve communication and coordination of care with other providers
- Vendor Marketplace – RI REC's Vendor Marketplace is composed of pre-qualified EHR software vendors, technical service consultants and health information service providers (HISPs). the REC helps providers assess vendor options, makes cost and functionality comparisons to simplify the vendor decision-making process.
- Health IT Certification - The RI REC is one of just four Regional Extension Centers that have partnered with Health IT Certification, LLC to provide training in four professional certification programs: Certified Professionals in: Electronic Health Records, Health Information Technology, Health Information Exchange, and Operating Rules Administration (Rhode Island Quality Instiute).

Health Information Exchange: Rhode Island's Health Information Exchange, Currentcare, was initially created in 2004 through a AHRQ grant to the Department of Health in partnership with RIQI. RIQI was designated by the state as its Regional Health information exchange organization in 2008 In 2010, RIQI's received $11.28 million in ARRA grants of which $5,280,000 in funding to "assist RIQI in implementing an integrated information exchange to improve health outcomes, reduce medical errors, and make our health care delivery system more effective and efficient" (Rhode Island Quality Institute, 2010). Currentcare is structured as an opt-in HIE service where patients choose to share all of their information to create longitudinal health care record across health care providers. In addition to agreeing to have their information become part of CurrentCare, patients can choose one of two options: either with all/some of their providers or only in an emergency.

As of the end of September 2013, Currentcare had enrolled 319,000 residents with a total of 345,000 projected to be enrolled by the end of the year. There are multiple data sharing partners who contribute data to current care including ten hospitals sending ADT feeds, seven Hospital sending Laboratory data (three more expected by end of year), two large clinical laboratories, 28 Medical practices (33 expected by end of year), two community mental health centers, seven large chain pharmacies and one large diagnostic imaging center for reports (MRI, CT, XRAY, US).

Additionally, the patient opt-in requirements have prompted private market initiatives around increasing the enrollment of Rhode Islanders in CurrentCare. In September 2013, BlueCross BlueShield of Rhode Island and RIQI released information on their joint incentive program for providers to assist in increasing patient enrollment. "Under the incentive program, eligible providers (those in family practice, pediatrics or internal medicine who are in compliance with BCBSRI's EHR Payment Policy) may receive up to $10,000 in incentives per practice related to three key areas:

- CurrentCare enrollment –To qualify for incentives, PCP practices must enroll the greater of the following: at least 200 patients per affiliated PCP or enroll a number of patients equivalent to at least 50 percent of their BCBSRI members.
- Use of the CurrentCare Viewer and Hospital Alerts—PCP practices can qualify for additional incentive if at least 75 percent of the staff is trained on the online portal known as CurrentCare Viewer and the practice enables CurrentCare Hospital Alerts.
- Implementation of a Direct Messaging Account—This allows for secure electronic communication between providers that use different electronic medical record systems" (Rhode Island Quality Institute, 2013)

KIDSNET: the Rhode Island Department of Health maintains a separate health information database for its pediatric population called KIDSNET. KIDSNET is Rhode Island's computerized child health information system designed to serve families, pediatric providers, and public health programs. Operational since January 1, 1997. KIDSNET captures information on all children born in the state as well as from children born out of state who see a Rhode Island Participating doctor or receive services from a program participating in KIDSNET (Rhode Island Department of Health, 2013).

Focused on screenings and ensuring that children receive the right preventive care at the right time, KIDSNET collects information from:

- Birth Records
- Immunization information from health care providers that immunize children
- Laboratory reports from Newborn Bloodspot
- WIC (Special Supplemental Nutrition Program for Women, Infants and Children)
- Healthy Homes and Childhood Lead Poisoning Prevention Program
- Early Intervention
- Newborn Developmental Risk Assessment
- Rhode Island Hearing Assessment Program & audiologists
- First Connections Program (home visiting)
- Birth Defects Program (Rhode Island Department of Health, 2013)

All Payer Claims Database: Rhode Island is building an All Payer Claims Database ("APCD") as a partnership initiative administered by an interagency workgroup including the Department of Health ("DOH"), Executive Office of Health and Human Services ("EOHHS"), the Office of the Health Insurance Commissioner ("OHIC"), and the HealthSourceRI (the health benefits exchange). The APCD will allow for:

- Longitudinal tracking of individuals across insurance carriers at the individual provider level;
- Robust reporting and analysis to aid and improve the calculation of risk scores;
- Measuring utilization and spending;

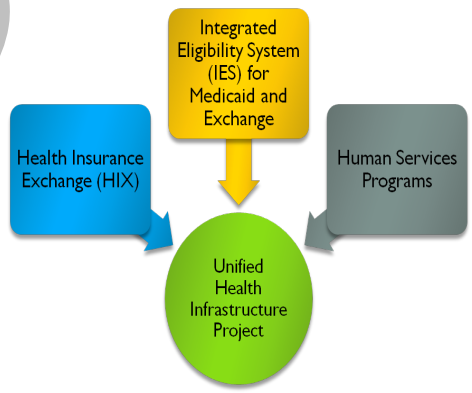
At the time of submission, a data submitter workgroup reviewed and finalized the technical specifications and operationalization of the ACPD. These regulations were finalized and include strong privacy protections for consumer data as well as data review boards. Additionally, the interagency group completed and submitted a Request for Information (RFI) and a Request for Proposals (RFP) and hired vendors to administer the APCD. The choices included:

- Freedman Healthcare: project management vendor
- Onpoint Health Data: data aggregator responsible for preliminary data intake and collection, data structure and format checks, creating person level extract
- (TBD by time of submission) Encrypted Unique Identifier Vendor responsible for creating unique IDs for patients, attaching payer's eligibility files, and returning data to payers

Unified Health Infrastructure Project: In recognition of the need for increased interoperability, Rhode Island created the Unified Health Infrastructure Project (UHIP) designed to be a single technical platform that will support the Health Benefits Exchange, Medicaid eligibility, and other state human service program eligibility. UHIP serves as a centralized resource for additional health information deemed necessary and appropriate. UHIP is an interagency initiative between HealthSourceRI, Executive Office of Health and Human Services (EOHHS), and the Office of the Health Insurance Commissioner (OHIC).

At the time of submission, the technical vendor for UHIP was chosen (Deloitte), user testing is complete, functionality is approved, and initial deployment occurred on October 1, 2013. The initial phase included information on HealthSourceRI and Medicaid (RIteCare) eligibility for the expanded population. Outreach and communication around HealthSourceRI and Medicaid expansion are underway via mass media and targeted marketing approaches. The state is in the final stages of creating a plan around metrics and evaluation around the continued use of UHIP. The state intends to incorporate publically reported quality measures in order to assist individuals with the purchase of insurance and the choice of a provider.

Below is a graphic explaining the function of UHIP:



History of Health Care Reform in Rhode Island

The State of Rhode Island has long been a leader in efforts to reform healthcare as a means to improving the health of its citizens. Even prior to 2010, when the Patient Protection and Affordable Care Act (ACA) was passed, Rhode Island had made a number of bold steps toward achieving the Triple Aim of better care for individuals, better health for populations and reducing per-capita costs.

Rhode Island's modern day efforts at systemic health reform can considered to be started in the early 1990s when the state undertook an effort to move parts of its Medicaid population to managed care. The RIte Care program was initially created for low-income children up to 250% of the Federal Poverty Level (FPL), but expanded to Medicaid eligible parents (185% FPL) in 1998 with care delivered through an HMO network. As a result of this expansion, the number of uninsured Rhode Islanders decreased to 6.9% in 1999, the lowest uninsured rate in the country at the time. In 2000, legislation created the RIte Share Program that would provide state premium assistance to families eligible for Medicaid with access to employer sponsored health insurance. The RI Department of Human Services was given the power to implement the program and public funds from CHIP, Medicaid and state dollars were used to subsidize the employer-sponsored insurance premiums for all eligible RIte Care participants who had access to such employer coverage. Today, RIte Care offers coverage to not only children and parents, but also to pregnant women (250% FPL) and participants can choose from 2 innovative managed care programs from either Neighborhood Health Plan of RI or UnitedHealthcare. The RIte Care and RIte Share programs cover roughly 120,000 Rhode Islanders.

In 2005, Rhode Island created the Executive Office of Health and Human Services (EOHHS) as a coordinating entity for those state departments that impacted the publically funded health care system. After legislation passed in 2006, EOHHS became a state agency led by the cabinet-level Secretary of Health and Human Services. EOHHS coordinates the fiscal matters, legal needs and policy direction of the Department of Health (RIDOH), Department of Human Services (DHS), the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) and the Department of Children, Youth and Families (DCYF). In 2009, EOHHS was designated as the single state agency for Medicaid.

With strong interest in using policy levers to ensure that its citizens receive quality care at affordable prices, the state established the Office of the Health Insurance Commissioner (OHIC) in 2004, through legislative action in the General Assembly. OHIC is the first state agency in the nation that has a Commissioner that is dedicated solely to health insurance oversight. Moreover, the Rhode Island legislature expanded the traditional role for insurance regulation beyond consumer protections and insurer solvency, to access and affordability and into such areas as mandated spending levels and the requiring of price transparency. Such a role, laid out in the OHIC *Purposes Statute* balances traditional regulation with policy development. The directive for the Office is laid out below:

a. Guard the solvency of health insurers;

b. Protect the interests of consumers;

c. Encourage fair treatment of health care providers;

d. Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and

e. View the health care system as a comprehensive entity and encourage and direct insurers toward policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

Since its inception, OHIC has introduced several key pieces of regulatory reform that have directly impacted the health of Rhode Islanders, notably the Affordability Standards and their associated requirements for primary care investments.

The Affordability Standards were created in 2009 and implemented in 2010. This is a set of criteria that directs commercial health insurance issuers with significant market share in Rhode Island. Together, these criteria are aimed at improving the affordability and quality of health care in Rhode Island. Specifically, the Affordability Standards require issuers to:

1. Expand and improve primary care infrastructure

2. Spread the adoption of the patient-centered medical home

3. Support CurrentCare, the state's health information exchange

4. Work toward comprehensive payment reform across the delivery system

In the first Affordability Standard, OHIC established requirements for primary care investment to facilitate delivery system reform in Rhode Island. The standard requires insurers improve the state's primary care infrastructure by increasing the share of total medical payments made to primary care by one percentage point per year from 2010 to 2014. The issuers are forbidden from passing these increases onto employers through higher premiums. OHIC also sets the percentage of primary care spending that must be paid through means other than fee for service rate increases. This is an example of the transparency that Office of the Health Insurance Commissioner has the authority to encourage, monitor, and enforce.

The Rhode Island Chronic Care Sustainability Initiative (CSI-RI) is a collaborative, all-payer PCMH effort of over 45 practices and 14 Community Health Centers that date back to 2008 when it was initially established by the Office of the Health Insurance Commissioner. Today it provides care to 250,000 Rhode Islanders. This program includes the largest payers in the state: Blue Cross and Blue Shield of Rhode Island (BCBSRI), Medicaid, Neighborhood Health Plan of Rhode Island (NHPRI) and United Healthcare of New England and Medicare. All of the payers in CSI-RI agree to pay a per-member, per-month fee for care coordination as well as pay for the services of a care management nurse (Robeznieks, 2008). Payment rates are tied to achievement of clinical quality, utilization and process improvement targets. Early results from the program show that CSI patients had lower inpatient stays than a comparison group of non CSI patients (for the first five years of the program). However, while CSI patients overall had a higher number of ED visits than a comparison group of non CSI patients, there is a downward trend in ED visits per 1000 member months over the first five years of the program. The

comparison group shows an upward trend. (Rosenthal, Friedberg, Singer, Eastman, Li, & Schneider, 2013)

In the Spring of 2010, Elizabeth Roberts, the Lieutenant Governor, established a 150 member Healthy RI Task Force to determine how Rhode Island could best respond to the opportunities and challenges presented by the ACA. This volunteer task force was made up of a broad range of stakeholders that ultimately became the foundation for the recent SIM design workgroup membership: hospitals, payers, providers, community activists and others. Their tasks were to look at such possible reforms in the areas of the insurance market coverage and expansion, opportunities in long term care, workforce development issues, payment realignment and delivery system reform, prevention and to begin to lay the foundation for the State's Health Insurance Exchange. The group issued a report in September of 2010 that presented the findings and recommendations of that Task Force.

Upon being elected Governor in November 2010, Lincoln Chafee established a Rhode Island Healthcare Reform Commission as soon as he took office, appointing Lieutenant Governor Roberts as its Chair. With its Executive Order, the Commission is directed to "address specific issues in healthcare reform, including but not limited to implementation of national reforms under the federal Affordable Care Act." The Commission established seven workgroups: exchange development, payment and delivery reforms, data and evaluation, workforce needs, policy and legal issues, communication and outreach, and long term care. To coordinate the activities, there is an 'Executive Committee' within the Commission which reports regularly to the Governor with specific recommendations.

Rhode Island's Health Insurance Exchange, HealthSourceRI, was formed as a result of an additional Executive Order by the Governor. Since this time, Rhode Island has been committed in its efforts to establish a public health insurance exchange, and is notable in that it achieved many of the required steps as one of the first states to do so. For example, the state was the first in the nation to receive a level two exchange establishment award from the federal government as a result of its bids for a planning grant and level one establishment award (Urban Institute, 2012). HealthSourceRI opened successfully on October 1, 2013.

The Director of HealthSourceRI is committed to its development as a tool to continue to push for reform in the State. Integrated into HealthSourceRI is a "one-stop" enrollment opportunity for residents to enroll in State Programs for which they meet eligibility, and the Director's ultimate plan is to use the site to publish quality data on each of the payers and their effectiveness at reaching specific population health goals. The State looks forward to the long-term development of the Exchange and views its launch as a key moment of healthcare reform in Rhode Island history.

The State has been a leader in the efforts to expand Medicaid, which it first began in the 1990's when it raised the coverage levels to children and parents up to 250 and 175 percent of the federal poverty level, respectively (Urban Institute, 2012).

Rhode Island also has a long history in health prevention and wellness efforts. The Department of Health (RIDOH) is the only government public health entity in the state; the counties do not have local departments. RIDOH has numerous programs that seek to promote population health and to reduce

the disparities in health by focusing on healthy child development and the prevention of disease and disability. RIDOH has provided leadership in many areas for the development of this SHIP, including establishing a model of community health workers with its Certified Diabetes Outpatient Program and its use of Certified Diabetes Outpatient Educators (CDOE's). RIDOH also supports a Family/Peer Resource Specialists program to support the needs of primary and specialty providers. Over 300 providers reached out to this program in 2012 (Rhode Island Department of Health, 2013). The RIDOH also supports efforts to reduce racial and ethnic health disparities. In the past, RIDOH was able to support Minority Health Promotion Centers that addressed health needs of minority communities (insert cite from DOH website here.) Although there are no county health departments, some of the cities, notable Providence and Warwick, have staff that focus on improving health in the community.

Current Federally Supported Programs in the State, including existing demonstrations and waivers granted by CMS:

Rhode Island's healthcare system currently operates with the support of a number of federal programs, both within and outside of Centers for Medicare and Medicaid Innovation (CMMI). These programs serve as the foundation of the innovations that will continue to transform and improve Rhode Island's healthcare in the coming years.

Current CMMI Projects and Awards

HealthCare Innovation Awards: These are three-year grants that are provided to organizations to implement new ideas in order to deliver better care to Medicare, Medicaid and the Children's Health Insurance Program CHIP recipients. The RI recipients are presently : Health Resources in Action, Women and Infants Hospital, and the University of Rhode Island.

From CMMI website:

The Health Care Innovation Awards are funding up to $1 billion in awards to organizations that are implementing the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and Children's Health Insurance Program (CHIP), particularly those with the highest health care needs.

The Health Care Innovation Awards Round Two are funding up to $1 billion in awards and evaluation to applicants across the country that test new payment and service delivery models that will deliver better care and lower costs for Medicare, Medicaid, and/or CHIP enrollees.

FQHC Advanced Primary Care Practice*:* East Bay Family Health, Thundermist Health Center of Warwick and WellOne Primary Medical and Dental Care all are in their first year of funding for this PCMH demonstration project.

From CMMI Website:

The Federally Qualified Health Center (FQHC) Advanced Primary Care Practice demonstration will show how the patient-centered medical home model can improve quality of care, promote better health, and lower costs

This demonstration project, operated by the Centers for Medicare and Medicaid Services (CMS) in partnership with the Health Resources Services Administration (HRSA), will test the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for up to 195,000 Medicare patients.

Participating FQHCs are expected to achieve Level 3 patient-centered medical home recognition, help patients manage chronic conditions, as well as actively coordinate care for patients. To help participating FQHCs make these investments in patient care and infrastructure, they will be paid a monthly care management fee for each eligible Medicare beneficiary receiving primary care services. In return, FQHCs agree to adopt care coordination practices that are recognized by the National Committee for Quality Assurance (NCQA).

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Bundled Payments: Kent Hospital, Newport Hospital, Rhode Island Hospital, The Miriam Hospital and multiple home health agencies are operating with Bundled Payment Models Two and Three, in which payments are structured around an episode of care (Two: Acute and Post Acute, Three: Post Acute Episode Only.)

From CMMI website:

Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality, more coordinated care at a lower cost to Medicare.

In Model 2, the episode of care will include the inpatient stay in the acute care hospital and all related services during the episode. The episode will end either 30, 60, or 90 days after hospital discharge. Participants can select up to 48 different clinical condition episodes.

For Model 3, the episode of care will be triggered by an acute care hospital stay and will begin at initiation of post-acute care services with a participating skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency. The post-acute care services included in the episode must begin within 30 days of discharge from the inpatient stay and will end either a minimum of 30, 60, or 90 days after the initiation of the episode. Participants can select up to 48 different clinical condition episodes.

Community-based Care Transitions Program: Carelink, Inc. was awarded the Community-based Care Transitions Program (CCTP) from CMS under the Innovation Center. Carelink is in partnership with Lifespan's Rhode Island Hospital and Miriam Hospital, as well as Chartercare's

Roger Williams Hospital and Our Lady of Fatima Hospital to target four diagnoses (CHF, COPD, MI and PENU) and improve the transition experience of discharged patients.

> *From CMMI Website:*
>
> *The Community-based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measurable savings to the Medicare program.*

Advanced Payment ACO Model: This is composed of physician-based and rural providers that volunteer to provide coordinated Medicare delivery. Coastal Medical, the largest primary care group in Rhode Island, is participating in this effort.

> *From CMMI Website:*
>
> *The Advance Payment Model is designed for physician-based and rural providers who have come together voluntarily to give coordinated high quality care to the Medicare patients they serve. Through the Advance Payment ACO Model, selected participants will receive upfront and monthly payments, which they can use to make important investments in their care coordination infrastructure.*

State-wide CMMI Awards

Multi-Payer Advanced Primary Care Practice: Under this demonstration, fee-for-service Medicare joined the state-based "Chronic Care Sustainability Initiative" multi-payer medical home demonstration. RI is one of eight states chosen to participate in this unique state-federal partnership, where CMS agreed to join multi-payer demonstrations based on state-designed payment and delivery system reforms.

> *From CMMI Website:*
>
> *Under this demonstration, CMS will participate in multi-payer reform initiatives that are currently being conducted by states to make advanced primary care practices more broadly available. The demonstration will evaluate whether advanced primary care practice will reduce unjustified utilization and expenditures, improve the safety, effectiveness, timeliness, and efficiency of health care, increase patient decision-making and increase the availability and delivery of care in underserved areas.*

Medicaid Emergency Psychiatric Demonstration: This is a test for Medicaid's ability to reimburse private psychiatric hospitals for services that were previously not reimbursable.

> *From CMMI Website:*

The Medicaid Emergency Psychiatric Demonstration was established under Section 2707 of the Affordable Care Act to test whether Medicaid programs can support higher quality care at a lower total cost by reimbursing private psychiatric hospitals for certain services for which Medicaid reimbursement has historically been unavailable.

This demonstration will provide up to $75 million in federal Medicaid matching funds over three years to enable private psychiatric hospitals, also known as IMDs, to receive Medicaid reimbursement for treatment of psychiatric emergencies, described as suicidal or homicidal thoughts or gestures, provided to Medicaid enrollees aged 21 to 64 who have an acute need for treatment. Historically, Medicaid has not paid IMDs for these services without an admission to an acute care hospital first.

Other Federally Supported Health Care Reform Efforts in Rhode Island

Medicaid 1115 Waiver: Rhode Island recently submitted an extension request to its current 1115 Waiver. The original waiver allowed Rhode Island to operate the entire Medicaid program under a single 1115 demonstration. The RI Medicaid Reform Act of 2008 directed the State to apply for a "global" demonstration under the authority of Section 1115(a) of Title XIX of the Social Security Act. The Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration (*1115 Waiver*) established a new Federal-State agreement that provides the State with substantially greater flexibility than is available under existing program guidelines. The State has used the additional flexibility afforded by the waiver to redesign the State's Medicaid program to provide cost-effective services that will ensure beneficiaries receive the appropriate services in the least restrictive and most appropriate setting.

The 1115 Waiver has three major program goals: to re-balance the publicly funded long-term care system, to ensure all Medicaid beneficiaries have access to a medical home and to implement payment and purchasing strategies that ensure a sustainable, cost-effective program.

The 1115 Waiver savings fell short of promised levels, in part because the State realized that many of the elderly Medicaid recipients that could have been eligible to be transferred out of long term care facilities, did not have safe, community-based housing to return to. The State recently submitted an extension request with a specific focus on enabling funds to be used to support housing.

Medicaid Health Homes Although CMS financial support recently ended, Rhode Island continues to support two of these Medicaid innovative complex care delivery models; one is for the pediatric population and builds upon a pre-existing program called Comprehensive Evaluation, Diagnosis, Assessment, Referral and Reevaluation (CEDARR). The other is an adult focused program that is for the serious and persistent mentally ill population. The adult program is managed by Community Mental Health Organizations. According to CMS, health homes are

designed to serve Medicaid enrollees who meet one of the following criteria (Centers for Medicare and Medicaid Services, 2010):

- Have 2 or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition

Early data show that the CEDARR program is resulting in improved quality of life for families using the program.

Money Follows the Person (MFP). In April 2011, a Money Follows the Person demonstration grant was awarded to Rhode Island. A five year, 27 million dollar grant provides Rhode Island with support to achieve its goal of rebalancing the long term care systems. The goals are to support the transition of individuals out of long term care facilities and back into their home through the use of improved home and community based services as well as to eliminate the barriers and mechanisms in state laws, state Medicaid plans or state budgets that prevent or restrict the flexible use of Medicaid funds.

Medicaid Adult Quality Measures Grant: This is a two-year grant designed to support state Medicaid agencies develop staff skills and capacity to collect, report and analyze data on the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Centers for Medicare and Medicaid Services, 2013). Rhode Island is one of twenty-six states awarded this five year grant.

Integrated Care Initiative (Commonly referred to as the "Duals Initiative"). This is a federal alignment initiative to better coordinate care for those individuals who are eligible for both Medicare and Medicaid. CMS has offered funding in order to test two models for States to improve the alignment between the financing of these two programs and integrate primary, acute, behavioral health and long term services and supports for their Medicare-Medicaid enrollees. One is a fully capitated model and the other is a managed fee-for-service model.

In keeping with Rhode Island's desire to quickly implement those health care reforms that are expected to result in the highest quality care while decreasing the growth in cost, it has chosen the capitated care model for its 35,707 dual-eligible citizens. Three entities are participating in the Duals Initiative in Rhode Island: Neighborhood Health Plan of Rhode Island, which has long been a managed care payer for Medicaid, the PACE program, which has used a capitated approach to coordinate care since its inception in 2005 in Rhode Island and Rhody Health Partners which manages care through a primary care medical home.

Safe Transitions Program: Managed by Healthcentric Advisors, the Safe Transitions Program is underway as a competitive Medicare Quality Improvement Organization effort. It was designed to decrease patient re-admission rates and therefore, Medicare expenditures, by coaching patients to better self-manage their care and by improving patient/provider communications.

Federally Supported Healthcare Information Efforts in Rhode Island

In 2010, Rhode Island received $11.28 million from the American Recovery and Reinvestment Act (ARRA) in the form of grants to the Rhode Island Quality Institute ("RIQI") for investments in Health Information Technology$6M helped establish the Regional Extension Center (REC), which was designed to assist providers with EHR implementation and in achieving Meaningful Use. RIQI is an independent, non-profit organization dedicated to improving health care for all Rhode Islanders. Through the REC providers receive expert advice on Meaningful Use and benefit from education, training, resources and HIE programs and services.

Trailblazers: Organized by the State Health Information Exchange Program in the office of the National Coordinator for Health Information Exchanges, in the Department of Health and Human Services, The Trailblazer program is an effort to align Healthcare Information Technology with Health Care Reform Efforts. Rhode Island joined these efforts in Phase 2, in November 2012. Through this program, states are studying the best approaches to the collection of data and how to harmonize measures across providers and payers. Also of concern is reporting, and how to ensure that such data actually support improvements in day to day delivery of care. According to the program website, Infrastructure will be developed to advance five critical goals:

1. Measure state progress in furthering the triple aim of better care, better health, and lower costs.
2. Use validated performance measures to reward providers through payment reform.
3. Use provider-level performance data to strengthen quality improvement initiatives by offering timely and comprehensive feedback.
4. Reduce the reporting burden through a streamlined, electronic data gathering system.
5. Develop models (e.g., action plan templates) that other states can adopt when building quality improvement infrastructure.

Beacon Community Cooperative Agreement: In 2010, this program provided $15,914,787 over three years to the State of Rhode Island as part of a demonstration of how health IT investments and Meaningful Use of EHR's can support the movement toward patient centered care (The Office of the National Coordinator for Health Information Technology, 2012). Rhode Island was one of 17 recipients of funds to support the efforts to strengthen the use of IT in healthcare. According to the program website, the key areas of focus for these projects were:

1. Building and strengthening the health IT infrastructure and exchange capabilities within communities, positioning each community to pursue a new level of sustainable health care quality and efficiency over the coming years;
2. Translating investments in health IT to measureable improvements in cost, quality and population health, and;

3. Developing innovative approaches to performance measurement, technology and care delivery to accelerate evidence generation for new approaches

The Beacon Communities Projects, as implemented in Rhode Island was coordinated by RIQI.

RHODE ISLAND'S HEALTHCARE CHALLENGES

Rhode Island is currently ranked 10th out of the 50 states on an overall health ranking (United Health Foundation, 2012) and Hospital Association of Rhode Island's Community Health Needs Assessment ((Hospital Association of Rhode Island, 2013) determined that 83% of Rhode Islanders reported "good," "very good" or "excellent" when asked to rate their general health, compared to 81.8% nationally.

Despite these statistics, Rhode Island still faces many challenges in terms of the overall cost of its healthcare system and the level of health achieved by its residents. The total cost of care annually in Rhode Island is 12.5 billion dollars.

Rhode Island's chronic disease rate mirrors the national average in many groups but is higher in others. For example, 10.9% of Rhode Island adults are diagnosed with asthma compared to the 9.1% national rate (Hospital Association of Rhode Island, 2013). Rhode Island has a high rate of cardiovascular and cancer deaths, both ranked 29th best in the country. (United Health Foundation, 2012) Rhode Island also has a high preventable hospitalization rate among its Medicare population, 70.6, which is 36th best, nationally.

The additional problems identified below are not exhaustive but must be addressed in order to improve the health and health care delivery of and for Rhode Islanders. Many of these challenges are also shared by other states in the nation. These problems represent the most significant challenges that Rhode Island intends to address through its State Healthcare Innovation Plan specifically through changes to the payment and delivery system. The areas of focus were chosen for their short and long term positive effects for the State's health care system and health of its population.

1. **Current fee for service environment leads to higher unnecessary or inappropriate utilization and doesn't incent coordinated care delivery.**

Most commercial insurance dollars in health care are spent in a fee-for-service manner (Rhode Island Office of the Health Insurance Commissioner, 2012). It is widely acknowledged that allowing consumers the ability to choose among non-integrated medical providers without any knowledge of the cost involved often results in higher costs with no improvement in health outcomes (Enthoven, 2009).

2. The system of care delivery is fragmented, which can lead to overutilization and higher costs.

In Rhode Island, there are a high number of independent practitioners and an insufficient infrastructure to coordinate and manage care across providers and healthcare systems. Physicians and other providers have few incentives and limited ability to follow patients as they proceed to specialists or change health care settings, such as transitioning back to the home after a rehabilitation stay in a long term care facility.

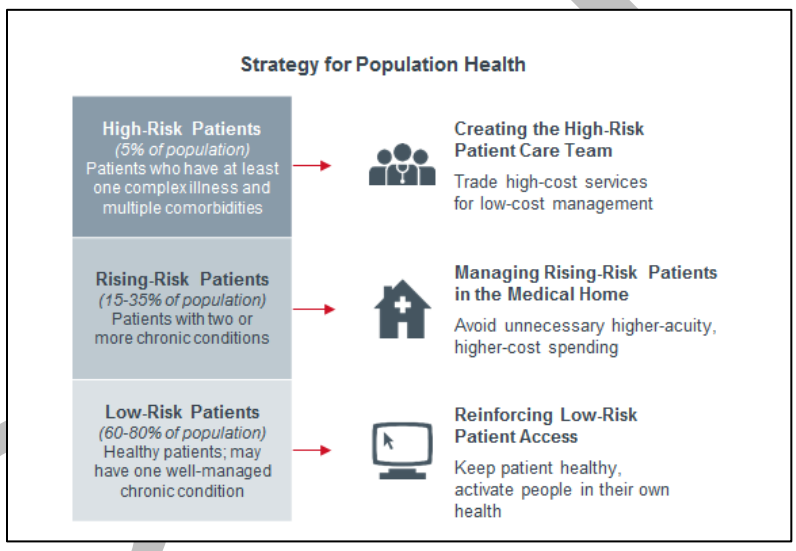
3. **Current practice of care transitions increase vulnerability of readmissions/reduced adherence to evidence based procedures, poorer health outcomes (all of which contribute unnecessary costs)**

Care transitions, such as those from hospital to home or from a hospital to a long term care facility increase the vulnerability for risky events in the life of a patient. Poorly executed, they can diminish health and drive up costs (Health Affairs, 2012) Care plans must be understood by and communicated across care givers. For vulnerable populations, such as the elderly, a poorly managed transition can result in a poor patient experience and outcome as well as an expensive and unnecessary re-admission. These potential poor outcomes lead to higher costs and higher rates of morbidity and mortality for the patients.

4. **The highest risk (top 5%) population is costly due to multiple-co-morbidities and requiring a high intensity of services.**

Rhode Island has conceptualized its population health as being comprised as three groups: High-Risk, Rising Risk and Low Risk. (See Figure 1).

Figure 1



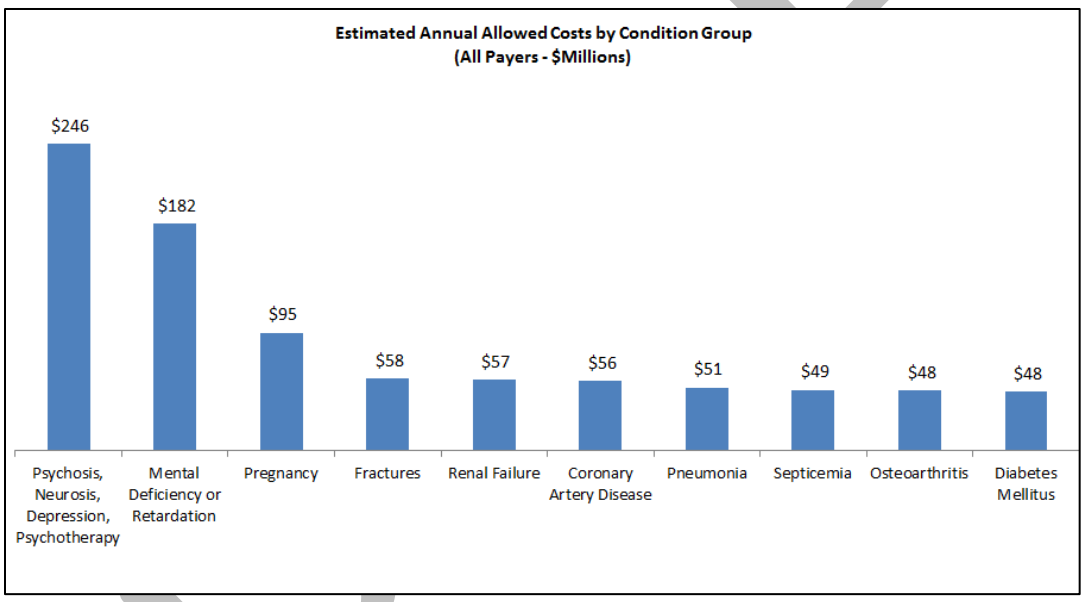
The populations with the highest levels of illness are responsible for a disproportionate amount of healthcare spending. For example, according to a Milliman actuarial analysis, in 2012 the top 1% of health care utilizers represented 29% of total spend for commercial, 23% for Medicaid and 13% for Medicare.

5. **Many Rhode Islanders in the population referred to as the "Rising Risk" population (those with one or two chronic conditions) receive uncoordinated and disparate preventive care that leaves them vulnerable to higher costs and in danger of rising to the high risk category. Similarly, the low risk population has low engagement with the healthcare system due to their relative good health.**

The rising risk group represents about 15% of the population and the remainder fall in the low risk category. Without successful education, change in life-style and prevention efforts, the rising and low risk populations will move up the scale at the same or increased current rate due to behavioral patterns like smoking or over eating, if no interventions are made.

6. **Rhode Island is concerned about the prevalence of mental illness and substance abuse, as well as the high cost of treating these conditions**.

Behavioral Health diagnoses appear in top three highest diagnoses across Medicare, Medicaid, and commercial payers. Accordingly, behavioral health problems represent the most costly condition and at a higher rate than the national average. The analysis by Milliman revealed that across all payers (Commercial, Medicaid and Medicare), the diagnosis group that included psychosis, neurosis, depression and psychotherapy had the highest estimated allowed costs of all diagnosis groups analyzed (See Figure 2).



The state-wide community health needs assessment report provides additional empirical support to the widely-acknowledged problem of Rhode Islanders having higher than average mental health illness (Hospital Association of Rhode Island, 2013). For example, Rhode Island residents were more likely to report "one or more days of poor physical or mental health in the previous month" than were residents across the nation. Looking specifically at substance abuse, Rhode Island ranks 35th in the nation on binge drinking measures (United Health Foundation, 2012) and roughly 48% of RI adults report smoking at least 100 cigarettes in their lifetime which is above the US figure (44.8%). Among Rhode Island residents who are still smoking, 63.2% have attempted to quit in the last year, which is also higher than the US average indicating a motivated population to improve its health.

7. **Lack of consistent transparency among providers and payers inhibits consumers from selecting care based on value**.

There is no formal, reliable, centralized approach to inform consumers, payers or providers as to the cost and quality of health care services in Rhode Island. Furthermore, there is no ability to compare providers across the state. As consumers share more and more of the health care burden, transparency of cost and quality information becomes critical to the decision process.

8. **There are unrealized opportunities for the healthcare system to incent higher levels of patient engagement**.

Years of experience within fee-for-service structures have taught patients that their healthcare is something that can only be understood and managed by physicians. The stakeholder interviews conducted as part of the design of this state Health Innovation Plan (SHIP) revealed that there are many areas in which healthcare providers and payers will soon be expecting patients to take a higher responsibility for managing their own health and healthcare choices. Given the relative lack of familiarity with the delivery system for the average patient, this raises concerns that Rhode Island residents may not yet be fully ready to take on these responsibilities.

9. **Community-based organizations are unevenly equipped to participate in healthcare and are poorly coordinated with the areas of greatest need**.

The variation in ability to collect and analyze data, among community groups, became apparent during the hours of discussion with community-based organization representatives during the SIM Model Design efforts. If community-based organizations are going to be expected to support patients and providers in their efforts to pursue healthy lifestyles and/or obtain needed social supports, then many of these organizations need to have more sophisticated tools and knowledge to support the tracking of patient outcomes.

10. **The current health care system allocates few resources to incorporating social determinants of health into the care delivery and payment system.**

It is known that it is the basics of social life that have the greatest impact upon the health of individuals. Influences on a person's life such as housing, access to nutrition, and safe neighborhoods are critical in the efforts of individuals to live healthy lives. Unfortunately, due to years of cost-cutting and political disagreement, the state has not had the ability to make significant investments in these areas.

Rhode Island understands that the social determinants of health affect the health of its population. Its housing stock is old, and according to the state Consolidated Plan, as of 2008, the median age of for the housing stock in the state was 1956. Over a third of the stock was built before 1939, which places it second in the nation for older housing, behind Massachusetts (Rhode Island Housing, 2010). Older housing carries significant health threats, especially when lower income families occupy these homes. This housing stock is directly related to the elevated rates of Childhood Lead Poisoning and asthma that plague residents of Rhode Island.

Additionally, the social environment can be challenging for Rhode Islanders in that the unemployment rate remains very high compared to the rest of the nation, and the rate of single parent households is among the highest in the nation, at 34.8%. Furthermore, the percentage of people over the age of 65 that live alone is at 31.1%, which is also higher than the national average of slightly less than 30% (Hospital Association of Rhode Island, 2013).

Ten percent of adults older than 65 live in poverty, compared to the national median of 8.4% (Hospital Association of Rhode Island, 2013).

11. **Data show that there are disparities between groups , e.g., Medicaid and commercially insured populations**

One key disparity is that Rhode Islanders between the ages of 18 and 64 who are on Medicaid and/or Medicare (Dual Eligibles) have higher rates of chronic diseases, such as a diabetes rate of 15% compared to 5% for those with private insurance. Risk factors are also higher for the publically funded groups: 32% of Rhode Islanders on Medicaid smoke, compared to 13% for those with private insurance; and obesity rates are higher among the Medicaid population as well, at 36% compared to 25% for the privately insured population. (RI Medicaid Research and Evaluation Project, 2012)

12. **Community Health Workers under-recognized**:

Despite the successful program at the Rhode Island Department of Health, in the marketplace that is considering new forms of value-based care, the definition of "Community Health Worker" remains unclear. Furthermore, awareness of the existence of this specialty and function is low among providers.

13. **Limited knowledge of how the current and future healthcare workforce is prepared to provide care in a value based system (both in training and in availability)**

As the health care system has created structures and reforms to move away from fee-for-service in the past decade, there had been a recognized need for new types of health care workers. Rhode Island has seen the advent of Community Health Workers, Nurse Care Managers and Health Analytics Specialists.

The state does not have current or complete data on its health care workforce, its training level or its distribution within the system. Additionally, the state does not have a forecasted demand for what the workforce needs will be under a system of population health management and coordinated care models.

14. Uneven expectations and knowledge around value-based care practices

As value-based care is still a relatively young concept in the planning efforts in Rhode Island, it appears that provider education programs are incorporating some of its principles into curricula at different rates and with different foci, if at all. The result is that providers are entering the workforce with different understandings of what's needed in a new system. Many providers that have participated in the SHIP Design process have reported frustration with their employees or colleagues in that they lack necessary skills for this new method of practicing healthcare.

15. Populations with complex or specialized health care needs face ad hoc, non-standard or marginal care structures.

Rhode Island's health care system has had varied levels of success in addressing the health care of persons with complex or specialized needs. Certain structures to address specific populations were creates auxiliary to the traditional system. Others were created as alternatives to the system, often from dedicated funding sources. Other health care needs are poorly addressed due to gaps in the system.

RHODE ISLAND's HEALTHCARE GOALS

Rhode Island aims to "bend the cost curve" of healthcare in Rhode Island and improve both the quality of health care and the overall health and sense of well-being of Rhode Islanders. By implementing the reforms outlined in this State Healthcare Innovation Plan (SHIP), the state expects to achieve these goals across five years.

In addition, as progress is made with healthcare reform and through leadership in all related agencies and departments– all major stakeholders will meet and identify the specific measures with which to gauge progress on the quality of care and the levels of health of Rhode Islanders. We anticipate that these measures will, to the greatest extent possible, build upon measures that are already in use by our Chronic Sustainability Initiative (CSI), and will not result in excessive additional data collection and analytic efforts by payers and providers.

Goal #1: The primary goal of the SHIP is to transition at least 80% of the covered lives in the state into value-based care arrangements, building on PCMH's as a foundation and transitioning through CMS models of value based payment such as Pay for Performance, Bundled Payments, and Shared Savings. These models help develop provider capacity to bear shared financial responsibility.

Goal #2: Bend the "cost curve" of healthcare in Rhode Island

Through the transition to value-based care, it is also the goal of Rhode Island to slow the rate of growth of healthcare spending. Health care legislation passed in the General Assembly in early 2013 included the authorization to review the Rhode Island's health system total cost of care, its drivers and to provide findings and recommendations.

Goal #3 Improve the Quality of Healthcare in Rhode Island

Quality and outcomes will be improved through the integration of primary care with community groups, hospitals and specialists. By building a robust analytic system at the individual and practice level, providers and payers will be supported in their efforts to deliver efficient and better coordinated health care to Rhode Island residents.

Targets:

- Reduction in 30d all-cause hospital readmissions,
- Reduction in 30d readmissions after hospitalization for behavioral health
- Reduction in ambulatory care sensitive emergency department visits
- Increase in timely interventions for behavioral health and substance abuse diagnoses
- Decrease in deaths from opioid overdose
- Increase in measures of timely access to primary care and behavioral health
- Increase in population-based measure of health-related quality of life

Goal #4 Improve the Quality of Rhode Islander's Health

As a result of this transition to value-based health care, with a core focus on quality, Rhode Islanders will enjoy the benefits of better health. They will have the support of health care teams, including health coaches, which will support their own efforts to be engaged patients and consumers. Residents with chronic care issues will enjoy better support in their efforts to manage their diseases, residents within health ranges will find additional support to help them stay there. Rhode Island will select appropriate population health targets from established population health programs such as Healthy People 2020 and Million Healthy Hearts.

THE STATE IS COMMITTED TO ACHIEVING THE GOALS IDENTIFIED IN HEALTHY PEOPLE 2020 AND MILLION HEARTS. THE STATE WOULD REQUEST INPUT ON SELECTING A SET OF APPROPRIATE POPULATION HEALTH TARGETS FROM THESE (OR OTHER) PROGRAMS.

In achieving all of these goals, Rhode Island aims to claim the #1 state ranking position by 2020 on the annual State Healthcare Ranking report from the United Health Foundation.

PROPOSED PAYMENT AND DELIVERY SYSTEM INNOVATIONS

Rhode Island is committed to the idea of health being a "state of complete physical, mental and social well-being and not merely the absence of disease and infirmity." To this end, Rhode Island recognizes that clinical and social service integration is necessary in order to support the quest of Rhode Islanders toward complete health at lower costs.

In order to create the clinical and social conditions that support complete health, Rhode Island is committed to supporting the transition from the current fee-for-service health care environment to a system in which providers are accountable for the health of the attributed patient population. The state will encourage payment models supported by CMS including pay-for-performance, bundled payments, and shared savings programs as steps to reach full shared financial responsibility. Through the organization of payers, providers and social services into structures that encourage efficient, high-quality and lower cost healthcare to the citizens of Rhode Island, the state will improve the health of its population while delivering appropriate care at lower costs.

Many payers and providers in Rhode Island are already in payment models that support this shift. With support from the state government, the market is expected to eventually shift most of the covered lives in the state into accountable payment models based on the concepts of Accountable Care Organizations ("ACO"). The goal is to provide care to 80% of Rhode Island's population through value-based contracts within five years. The state acknowledges that most entities will follow a continuum based on market maturity ranging from pay-for-performance arrangements, bundled payments, and shared savings into a mature, capitated model. Recognizing that the full benefits of integration for the improved health, care and costs of care for Rhode Islanders will be best realized under global risk, the Innovation Plan facilitates a shift into ACO's or ACO-like structures that support shared financial responsibility through the a series of incentives, investments, and technology and care management tools.

The key 15 challenges that Rhode Island is focused on will be addressed by a number of innovations to the Rhode Island healthcare system. Many of these innovations have been implemented by other states and others have been suggested by stakeholders involved in the SIM Design Process. Below are a series of tables that list each challenge, the innovations that are expected to address them and a high-level description of the tactical approach the state may take when addressing these challenges. Also included in these tables are the identification of potential outcome measures, the sources of potential data and an indication of how each intervention incorporates one or more of the key pillars of Rhode Island's reform efforts.

Due to considerable overlap of impact the innovations are expected to have, a detailed description of each innovation follows.

TABLE 1:

CHALLENGE: Fee for Service Leads to Higher Utilization and Cost:

Innovation/ Activity/ intervention	**How?**	**Outcome**	**How to measure outcome**	Pillars
Form coalition to encourage creation of ACO-like organizations in the commercial and public market	With the state as convener, bring players to the table to form work group –, to create contracting standards, identify regulatory and policy changes needed, new relationships between providers and payers	Lower overall health costs to state and payers; less duplication of services; lower utilization rates.	Cost of care project by OHIC; 33+ NCQA quality measures; PQRS	Multi-Payer Payment Transformation Accountability
Encourage the development of value-based options for state employees, retirees and municipalities to ACO-like structures	State as payer can increase # of RI's in value based care and payment arrangements by using its purchasing power to change the payment system.	State's health care costs decrease through lower utilization and improved quality of care	Claim data; quality metrics based on NCQA 33 measures; PQRS	Multi-Payer Payment Transformation Accountability
For Medicaid recipients and Dual Eligibles, develop state contracts for a primary-care led ACO that will manage and deliver full services on a shared-savings basis.	State as payer can increase # of RI's in value based care and payment arrangements by using its purchasing power to change the payment system	State's health care costs decrease through lower utilization and improved quality of care	Claim data; quality metrics based on NCQA 33 measures; PQRS	Multi-Payer Payment Transformation Accountability
Support steps toward full global capitation: from P4P, Bundled services, Shared Savings, to global capitation	Lower cost and utilization, improved primary care	33 quality measures(NCQA); PQRS		Multi-Payer Payment Transformation

TABLE 2

CHALLENGE: Care delivery is fragmented.

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
ACO-like organization's will create integrated delivery systems	Possible OHIC regulatory changes and ACO coalition; benefit design that encourages (doesn't limit) staying within network, within RI.	Better integration of clinical services, reduced duplication of services, improved communication and teamwork between providers	Increased EMR adoption; APCD, invest in business intelligence tools such as care and disease registries at state and provider levels , provider directory, increased adoption and use of CurrentCare	Patient / Consumer Centric
Incent data reporting, transparency, and consistency across providers, e.g., Provider Directory, CurrentCare, APCD. Maintain a common set of input and reporting standards for all data aggregation tools, including a harmonized set of measures for all payers and shared quality reporting infrastructure to serve as data intermediary for quality reporting and to provide feedback to providers and public	With state as convener, provider tools for provider organizations to communicate across interoperable systems; provide financial incentives for small and independent primary care practices to adopt and use technology that reduces fragmentation; develop and implement shared quality reporting infrastructure (intermediary) promote further expansion of Currentcare	Better integration of clinical services, reduced duplication of services, improved communication and teamwork between providers	Assess increased EMR adoption; APCD, invest in and monitor business intelligence tools such as care and disease registries at state and provider levels , provider directory, increased adoption and use of CurrentCare' monitoring of aggregated quality measures, monitoring of changes in practice based on quality measurement feedback to providers	Accountability Transparency
Grow PCMH model	Incent independent primary care doctors to transition into PCMHs and to contract with entities developing toward an accountable and shared risk structure.	Reduced hospitalizations including ED use, reduced duplication of services, improved health care experience/health for patients, better management of chronic diseases, reduction of high utilizers.	Track number of practices participating and patients being treated within model.	Multi-Payer Payment Transformation Patient / Consumer Centric

TABLE 3

CHALLENGE: Care Transitions are costly and lead to poorer health outcomes

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Expansion of Community Health Teams will provide resources to support, coordinate and aid patient transitions from hospital to/or LTC or home	Regulatory changes will be needed to ensure that payers contribute to the finance of this expansion over time. Some support will be provided from Medicaid under 1115 waiver, facilitate data sharing during transition of care through EHR adoption and meaningful use (MU) state 2 (has transition of care requirements to share data), alignment of MU and state Continuity of Care form, Currentcare adoption	Reduction in admissions, reduction in duplicate services, better patient experience and outcomes, reduction of high utilizers, fewer transitions overall	APCD, state continuity of care form, Currentcare, patient satisfaction surveys	Multi-Payer Patient / Consumer Centric Community Assets

TABLE 4

CHALLENGE: High risk population requires high intensity services and often over-utilizes the ED

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Community Health Teams: based outside of provider practices: includes lower care-giver to patient ratio, telemedicine, coordination with community resources; the use of Extensivists – especially for the Medicaid/Medicare populations specifically with behavioral health and pregnancy conditions; include Recovery Coaches in CHT's	Form care-giver teams of nurses, allied and community health teams within an ACO-like structure to address the needs of the top utilizers. Place case managers in ED's.	Reduced ED visits Reduced pre-term births Reduced readmission Higher recovery rates	Claim data; quality metrics (NCQA); hospital admission/readmission rates	Multi-Payer Patient / Consumer Centric Community Assets
Intermediate intensity services for highest cost Medicaid/Medicare population; provide an alternative to the Emergency Department where their needs can be met in a more appropriate setting;	Develop ambulatory ICU, sobering centers, home-based primary care – more work is needed to define these interventions.	Reduced ED visits, reduced hospitalizations		Payment Transformation Patient / Consumer Centric Accountability

TABLE 5

CHALLENGE: Rising risk population requires greater awareness of risk, and access to information, prevention activities and screening

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Promote healthy life styles Manage preventive care through the PCMH model Use technology, health risk assessments to track and report on progress at the provider or group level Use technology (e-health tools, patient portals), patient generated data to support patient engagement	Expand PCMH availability through positive incentives; marketing campaign in increase education and awareness for well and preventive care; develop patient portals and e-health tools for Currentcare Consider developing specialized PCMH's for behavioral health and/or substance abuse patients	Reduced number of patients entering into the high risk category in order to sustain savings realized by high risk interventions.	Increased collection and reporting on health status of RI; Community Needs assessment from HARI; tools connected to APCD	Patient / Consumer Centric Transparency Community Assets

TABLE 6

CHALLENGE: LOW RISK POPULATION NOT INTEGRATED INTO HEALTH CARE SYSTEM

Innovation/ Activity/ intervention	**How?**	**Outcome**	**How to measure outcome**	Pillars
Public education and health promotion campaigns, e.g., PSAs, that emphasize the importance of good health; focus on behavioral and maternity care; Increased preventive screenings, health risk assessments	Increase PCMH access, marketing campaign for education on the importance of well-care	Healthier more engaged consumers especially among young adults; increased patient engagement and activation; increased PCP visits	Community Needs Assessment, tools reporting on social determinants of health in coordination with the APCD	Patient / Consumer Centric Transparency Community Assets

TABLE 7

CHALLENGE: Behavioral health is costly and population health status is poor

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Co-location of behavioral health and primary care providers: Ensure adequate infrastructure for the most acute BH conditions; integrate lower level conditions with primary care.	This will be incented by all payers – including Medicaid paying for some services through the support of CHT specialists; sharing of behavioral health data through Currentcare	Improved access to BH for low acuity patients and improved access to primary care for SPMI	Lower costs; improved mental health outcome data; annual survey	Multi-Payer Payment Transformation Patient / Consumer Centric
Programs to support recovery programs for substance abuse treatment participants	Peer-led, voluntary support services	Improved outcomes		Patient/Consumer Centric

TABLE 8

CHALLENGE: Lack of transparency and accountability among payers inhibits smart consumer behavior

Innovation/ Activity/ intervention	**How?**	**Outcome**	**How to measure outcome**	Pillars
Improve ability to collect, analyze, find and distribute/report health care information through the introduction or improvement of HIT tools, such as statewide shared quality reporting infrastructure to benchmark and feed results back to providers and to support public reporting program	Identify an entity to take responsibility for creating/managing these tools and their governance; promote sharing of cost and quality information to the public	Provider Directory, APCD, Currentcare, harmonized measures, quality reporting data intermediary, increased HIE and EHR usage, Social Service Agency/Org. Directory, and identification of further options to promote interoperability	Claims data, quality measures, HealthSourceRI	

TABLE 9

CHALLENGE: Some Rhode Islanders can be disengaged and lack accountability for their own health and healthcare

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Provide Navigators, Require Personal Health Risk Assessments, Design Marketing and Communication campaign, patient engagement tools and currentcare patient portal, health promotion activities	Strengthen HealthsourceRI to take on these responsibilities, build out Currentcare portal, develop marketing communication campaign	Improved awareness and understanding of how health system works, and how to reduce one's own risk factors	Provider surveys, Hospital Association of Rhode Island's Community Health Survey	Patient / Consumer Centric Accountability Transparency Community Assets

TABLE 10

CHALLENGE: Community-based organizations vary in readiness to participate in health care

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Provide technical assistance services, collaboration group, empower CBO's to more directly address social determinants of health	Identify an entity to take responsibility for creating/managing these efforts	Improved integration of these organizations in the healthcare system; they will provide lifestyle supports and resources for providers	Tracking and monitoring number of organizations entering into partnerships with providers;	Community Assets

TABLE 11

CHALLENGE: The state government provides little focus on or resources to address the social determinants of health.

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Establish inter-agency education and information programs that articulate impact of social determinants of health on different agencies. Information will be routed in improved data collection and research on the social determinants of health of Rhode Islanders, and will include robust reporting on the economic and social implications of the relevant SDHs to each department	Incorporate healthcare awareness into city/state planning	Dissemination of information will incorporate the full definition of health into agency priorities and budget and agenda setting will start to reflect health of Rhode Islanders.	Tracking and monitoring the inclusion of health outcome oriented programs, policies, etc. over time.	Transparency Community Assets
Creation of a Healthcare Innovation Trust Fund	Provide continual funding for programs designed to address this need	The state and community will discover the best ways to influence these causes of poor health and health disparities; will increase awareness of and importance of the social determinants of health	Documenting the process of development and determining whether the goals of the intervention are being met.	Payment Transformation Community Assets

TABLE 12

CHALLENGE: There are health status disparities between different population groups

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Access through ACO-like organizations, common care protocols/guidelines and incentives will improve access and outcomes.	Move Medicaid population into ACOs that take on multi-payer clients; move payment to value-based with the potential for bonus or shared savings payments.	Decreased differences in key health outcome measures between groups.	Claim data; quality data (NCQA)	Payment Transformation Patient / Consumer Centric

TABLE 13

CHALLENGE: Community Health Worker definition is unclear; providers unaware of their existence and function

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Develop uniform credentials and license requirements for CHWs.	Integrate services within the PCMH model; include in provider directories; ensure awareness among care teams	A clear career path and opportunities for people with this credential; the creation of a pool of workers to support the expansion of value-based care.	Process evaluation and #'s of CHW's licensed or hired over time.	Multi-Payer Community Assets

TABLE 14

CHALLENGE: State possesses limited knowledge of current and future healthcare workforce supply and need

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Conduct thorough and comprehensive workforce assessment that provides a detailed understanding of the current and projected workforce available in Rhode Island as it's needed to provide value-based care to Rhode Islanders.	Use SIM grant funding to conduct thorough assessment that will use of DLT specialists and provide the state a model to manipulate as changes are implemented	Rhode Island will identify gaps in the existing workforce and the appropriate workforce pipeline to deliver value-based care at a lower cost to its residents. The identification of gaps will allow to strategic planning and solutions for the provision of cost effective, efficient, and appropriate care	Process evaluation/TBD	Transparency

TABLE 15

CHALLENGE: Uneven integration of value-based care principles into education curricula

Innovation/ Activity/ intervention	How?	Outcome	How to measure outcome	Pillars
Develop curricula for in-service training and schools. Develop coordinated curricula and programs/opportunities for previously siloed training programs to practice coordinate care in a training setting before graduating, also promote development of training programs that produce workers skilled in data analytics and interpretation	Utilize the findings of the focused assessment to identify the biggest perceived gaps for the future and work with involved parties to develop coordination programs.	Current workforce able to provide right care right time right place at the right cost for patients and their employers.	Process evaluation/TBD	Accountability Patient / Consumer Centric

In creating these interventions, Rhode Island supports the CMS assumption that when payment reform includes most risk-bearing providers, both payers and providers are better able to deliver higher quality health care at a lower rate of cost growth. An additional assumption is that the state – in its role as a purchaser convener, regulator, policy setter, and licensor – can provide critical authority, incentives, requirements, and assistance for the market to shift away from fee-for-service to value-based care.

The following is a list of innovations and activities that Rhode Island will undertake on its path to lowering the trajectory of healthcare spending while improving the quality of care and overall health of Rhode Islanders. Each innovation and activity works to support one or more pillars of Rhode Island's new system, as indicated. Intended target and outcomes are indicated in the above diagram.

1. Payment and Delivery Innovations and Tools

A number of new approaches and tools need to be developed to support the overall move of the current state health care system toward value-based care. The transition from a disconnected and disparate healthcare system to a value-based healthcare system requires investments in multiple innovations and

tools to support the transition. Currently, providers and payers in Rhode Island are moving at different paces toward adapting the principles of a system and the state will use all of its capabilities to enable the various members of the system to succeed in transitioning to value-based care within five years. Rhode Island acknowledges that many providers and payers have already begun the movement toward payment reform, and already pay and deliver care within value-based structures. The strategies and tools identified below are designed to both provide guidance and support to payers, providers, and citizens of Rhode Island as the state continues to reduce cost of care while improving the quality of care and health of to all Rhode Islanders.

- **Stakeholder Coalition to develop accountable care strategies and structure:** Establish a state-convened multi-stakeholder coalition to develop contract strategies, measurement strategies and shared learning for accountable entities. This coalition will also be instrumental in further identifying appropriate policy and/or regulatory changes that may be needed in the future. A coalition/work group structure is the same strategy used by the Office of Health Insurance Commissioner when it successfully sought to encourage the creation of Patient Centered Medical Homes. Market stakeholders have clearly articulated their desire for the state to retain its role as a convener as it seeks to implement health care reform in this state. Bringing together such a group as a multi-payer coalition will help drive accountability with payers and providers. Critical to the success of system-wide accountable care structures is the inclusion of all provider types. Behavioral health, long term care, dental and other oral health providers and a range of sub-specialties should be included in the accountable care collaborative.

- **Encourage value-based purchasing options for state and Municipal Employees, and Medicaid Fee-for-service members**: Using the leverage of the state's role as a purchaser of employee insurance coverage, Rhode Island will incorporate the principles of value-based care to encourage accountable purchasing options for state employees, municipal employees, early retirees and Medicaid recipients within a five-year time frame. Nearly all of Rhode Island's Medicaid population is under managed care. The next step for the Medicaid contracts in moving toward a value-based delivery system is to include financial responsibility measure to providers, through any number of arrangements such as, pay-for-performance, bundled payments, shared savings and capitation.

- **Rhode Island Care Transformation and Innovation Center (RICTIC)**
  Given the importance of collaboration, communication, and coordination as the state encourages the stakeholders in Rhode Island to transition into value-based care arrangements, the state will create or develop an entity that will provide assistance and support to the stakeholders during the next five years. The Care Transformation and Innovation Center (RICTIC) will provide technical assistance, convene resources (convene ACO stakeholder coalition) and facilitate future innovations (through the establishment of the Healthcare Innovation Fund). Each of these functions is described in its relevant section. The RICTIC will also be the hub for driving patient engagement, and coordinating these efforts with HealthSourceRI, as needed. The structure of the RICTIC is envisioned as a public-private

partnership with most activities centered and occurring outside of state government, and through community or market-led transparent activities.

THE STATE WOULD REQUEST SPECIFIC COMMENTS ON THE CARE TRANSFORMATION AND INNOVATION CENTER REGARDING ITS STRUCTURE AND SPECIFIC ACTIVITIES

- **Provide Technical Assistance:** It is anticipated that not all providers and payers will be able or willing to immediately shift into a full global risk-bearing payment agreement. Many independent physicians and practices are not fully prepared to enter into value-based contracting and lack the capital to invest in the tools necessary to deliver quality care under risk-based contracts. In Rhode Island, approximately 60% of the primary care physicians are either independent or in small practices. These entities need assistance – financial, educational and technical – to successfully transition to value-based care. To this end, the state intends to provide support and technical assistance to those entities adopting a graduated approach to global risk. These state resources, which would be delivered through RICTIC (described above) include:

    i. Provision of training and technical assistance for contracting and outcomes measurement

    ii. Provision of support to promote the harmonization of outcomes data

    iii. Provision of technical assistance with managing the needs of collecting, entering and analyzing health care clinical and claims data

    iv. Provision of support in re-training existing workforce with team-based skills

- **Use regulatory and purchasing powers to set contracting standards:** Coordinate and use the leverage provided by the Office of the Health Insurance Commissioner (OHIC), the Executive Office of Health and Human Services, the Department of Health and HealthSourceRI to require value-based structures for 80% of commercial payments to providers in increasing increments across the next five years. As an example of an effective use of regulatory power to affect a multi-payer outcome, HSRI will set standards for participating carriers as they build products and networks on the continuum of value-based care.

THE STATE WOULD REQUEST SPECIFIC COMMENTS ON TARGETS FOR TRANSITION TO VALUE BASED CARE AND THE WAYS THAT IT COULD BE PHASED IN OVER A 5-YEAR TARGET PERIOD.

- **Expanding the use of Community Health Teams (CHT's)** Building on the initial efforts of CSI-RI (the Rhode Island PCMH initiative), Rhode Island will encourage and expand PCMH's for the high risk and rising risk patient populations, particularly among providers that treat the Medicaid population. The Community Health Teams will be located outside of clinical settings, include ancillary services and contain specialized resources that focus on the diagnoses with the highest costs and needs in the state (including behavioral health, substance abuse, pregnancy and chronic diseases). The extension of the CHT program to the rest of the patients in the state will be accomplished using the regulatory powers of the Office of the Health Insurance Commissioner to incent their use in line with evolving market needs. As smaller practices enter into value-based care arrangements, components of Community Health Teams will be shared by multiple practices. Rhode Island will build off the success of CSI-RI's pilot CHTs in the Pawtucket and South County communities, and the state will incorporate the lessons gleaned from the evaluation of the pilots as it rolls out CHTs incrementally across five years. By using CHT's in their practices, providers will be better able to manage the expectation of accountability that value-based reform will require of them.

THE STATE WOULD REQUEST SPECIFIC COMMENTS ON COMMUNITY HEALTH TEAMS AND THEIR USE IN THE RHODE ISLAND SYSTEM

- **Specialized CHT Care Managers:** Encourage the development and use of CHT care managers in key areas to support Medicaid and Medicare high utilizers. Since our data show that Medicaid populations tend to have higher incidence of chronic conditions and concentration of ED visits, these specialized managers will include clinical specialists in the areas of ED visit reduction, behavioral health, substance abuse, chronic conditions and pre-natal care.

- **Intermediary Services for High Utilizers:** Recognizing that many of the highest utilizers of the emergency departments and Medicaid dollars also have behavioral health or substance abuse conditions, we will develop a series of intermediate intensity services for the highest ED utilizers. These services may include Sobering Centers, Home-based primary care and "Ambulatory ICU's" for high-need patients. These patient-centric interventions offer the benefit of providing the high intensity support and services that this population needs in a more appropriate, lower-cost setting. The state will determine the appropriate model for these intermediary services by the end of Year One.

- **Encourage the further development of PCMH's:** Building on the state's successful multi-payer demonstration, expand the effort to pediatrics and to additional adult primary care practices. In addition, the state will begin to involve specialists and hospitals in the PCMH coalition in order to support the "Medical Neighborhood" concept and maximize the opportunity to coordinate

care and decrease unnecessary utilization**.** Continue to encourage and incent the movement of practices into a PCMH model that focuses on the rising risk patients in Rhode Island (defined as approximately 15% of our population who suffer from at least one chronic disease). The PCMH model has served in Rhode Island and the nation as a foundation for integrating and coordinating care, improving accountability and setting the stage for succeeding in financial risk models. As a result of the lessons learned from the Pioneer ACO model adoption (Evans, 2013), Rhode Island will encourage providers and payers to enter "upside risk" agreements when they first begin value-based contracts.

A key area for PCMH development is in pediatrics, where a model based on CSI-RI is under development. Creating structures that focus on prevention and the building of health early in life have the potential to support future patient engagement and a better base for the maintenance of adult health.

- **Improve integration of community-based groups with primary care teams**: Encourage and support the integration of community-based organizations into the healthcare system: Through technical assistance, provide help to such groups that will become resources for primary care practices in their efforts to support and promote healthy lifestyles, and/or to provide access to basic supports such as housing and job training to fill deficiencies due to social determinants of health. Rhode Island seeks to build upon its community assets rather than creating new structures or organizations. , Many of the community-based groups in the state have been working successfully for many years; Rhode Island would best be served by these organizations taking larger leadership roles in our community in efforts to improve residents' health.

- **Create, Promote, and Support Comprehensive, state-Wide Data Aggregation and Analytic Tools:** Rhode Island will continue to develop and improve analytic tools that can be leveraged by the state, providers, and payers. These tools include a statewide Provider Directory, the All-Payers Claims Database and Currentcare, the Health Information Exchange**.**

    - **Centralized Aggregation Entity**. In order to remove the obstacle of cost and capabilities that all providers and payers face in their transition to value-based care, Rhode Island will create a single reporting entity that will draw upon the single source of clinical and financial data. Entities will be able to acquire all needed data to meet contracting requirements, manage costs and practice population health through this entity. This centralized aggregation entity will enable the state to:

        - Continue to harmonize quality, utilization, and cost measures;
        - Create transparent capabilities for cost, quality, and outcomes measurement reporting;

- Ensure predictive model capabilities exist and can be shared among small provider groups for identifying risking-risk patients;
- Interface with other single state-wide authoritative tools such as APCD, Currentcare, Provider Directory, UHIP and others

The centralized data and analytic center will provide a coherent framework publically reported cost, quality, and utilization data. Through a collaborative roll-out of reports and coordination review among provider groups, Rhode Island will educate the public on the value of transparency and a centralized health information system.

- **Continue to develop APCD:** As the APCD is developed, Rhode Island will ensure that the data and information it produces are secure, timely, accurate, relevant and trusted. Additionally, providers, payers, researchers, and the public will have input on how the data base can best enhance population health management and information transparency. Rhode Island will also explore the opportunity to develop a methodology to link de-identified claims data with de-identified clinical data outside of state operations in coordination with a private partner in order to allow for more robust comparison of similar patient groups. Rhode Island will commit to the interoperability and communication of the APCD with other essential data resources.

- **Expand the Structure of CurrentCare:** The expansion of CurrentCare will also improve the delivery of care through increased provider use and alerts, improving and incenting data sharing and interoperability with other health information platforms in the state. The specific patient engagement benefits (and development of the patient portal) are described in the section on Patient Engagement, below.

- **Provider Directory.** The comprehensive provider directory will act as a single statewide authoritative directory providing information on demographics, credentials (License number, NPI, Specialty), insurance network participation, languages spoken, office hours, and communication preferences. The provider directory will provide reliable and consistent information to state agencies, providers, payers, and the public for information on the providers of care in Rhode Island.

- **Social and Community Service Resource Directory.** Providers will need access to up-to-date information on community services that can support the health goals of their patients for a team-based approach to providing quality care. Rhode Island will support the development of a web-based directory that will contain accurate, geo-located descriptions and contact information of the

community-based services in Rhode Island. Services such as housing support, food/nutrition assistance, diabetes lifestyle management will be up-to-date and searchable, allowing members of the Integrated Care Teams to serve and connect their patients to valuable services.

- **Promotion of Health Information Technology and Measurement:** Rhode Island will promote EHR adoption among providers by aligning EHR incentive metrics and funding arrangements across major payers as a condition for value-based contracting. Additionally, Rhode Island will continue to assist providers with achieving meaningful use through continued funding, outreach, and education through the Regional Extension Center (REC). The REC will use its established competencies to provide funding and assistance to behavioral health providers who are ineligible for federal incentives achieve meaningful use.

  The state will continue an interagency approach in collaboration with Rhode Island Quality Initiative (RIQI) to educate providers and patients on the value of using Currentcare and its direct messaging capability for exchanging health information. As Currentcare use increases with primary care providers, the state will also work to expand specialists' use of the Currentcare viewer, which allows the physicians to open and view the data.

- **Increase Usability and Interoperability of Healthcare Information Technology**. In order to increase the interoperability and usability of provider facing technology, Rhode Island will also identify and develop options for implementing Federated Identity Management and "single-sign on" capabilities among systems in order to reduce the time spent switching between systems and easing the burden on patient facing providers. The state will also adapt its interoperability and health information exchange strategy as market conditions, needs and abilities evolve.

2. Workforce Development:

While changes to the payment, clinical, and technology models in the health care environment are all essential to building a value-based care system, it is the workforce delivering care to patients that is essential to executing on the vision for the future.

Rhode Island is building a workforce model for the future that is focused on realizing the triple aim and is both person-focused and supports providers moving to value-based care

In order make the next move into a value-based delivery system, Rhode Island has identified several important areas to focus on for its current and future workforce:

- **Develop uniform credentials and license requirements for Community Health Workers:** CHT's will be crucial in the success of value based care, and require the work of Community Health Workers. In order to ensure that they are able to fully execute their responsibilities and allow the other members of the Community Health Teams to work at the top of their licenses, these

members will need uniform credentials, training and licensing requirements. Uniform credentials will also allow for the ability of multiple payers to support their use.

- **Conduct a workforce assessment:** A focused strategic assessment will give Rhode Island an analysis of the current workforce in supply in comparison to future needs in a value-based delivery system and reform efforts outlined in this plan. In addition, the assessment will provide an on-going evaluation tool for Rhode Island to use as the system moves further into value-based care, which will continually assess and rationalize the workforce. This will be an important tool that will have continued value for building the appropriate workforce and workforce pipeline in Rhode Island.

  The assessment will evaluate opportunities for further integration efforts around**:**

  - Pharmacy
  - Co-location of services
  - Behavioral health (Currently under consideration by Health Care Planning and Accountability Council)
  - Long-term care
  - Certified professionals
  - Licensed professionals
  - Opportunities for telehealth

- **Develop curricula for in-service training for professionals as well as students:** Using the results of the focused assessment as well as other reports produced from assessments by OHIC and related entities Rhode Island will work to removed 'siloed' curriculum models and coordinate education and training of the health care workforce for a value-based system. In coordination with the Department of Labor and Training, the Department of Health, graduate training programs, and other participating agencies, the state will launch programs that:

  - Retrain the existing workforce and bridge existing gaps in today's workforce
  - Address certification and licensure gaps and barriers for new and existing professionals
  - Incentivize in-demand professionals to receive education and stay in Rhode Island through loan forgiveness programs or tuition payments
  - Coordinate and integrate the principles of the triple aim and a value-based delivery system across health care training programs for all member of the health care workforce with eye toward future workforce needs

Behavioral Health Innovations

While Rhode Island has a higher than national average rate of behavioral health diagnosis and treatment, research shows that different treatments are appropriate for different levels of mental illness. It is important to distinguish those with severe mental health problems, such as schizophrenia, from those with milder diagnoses such as low-level depression or anxiety. We envision that medical and behavioral health services will be implemented and accessible, with an emphasis on co-location in primary care. The short term the strategy of co-location in two different ways due to the differences in level of need between acute and moderate behavioral health diagnoses will be implemented. The creation of Community Health Teams will also support the improvement of care for these populations.

- **Co-Location Strategy #1:** Rhode Island will co-locate behavioral health providers at Primary Care delivery sites and screen regularly for behavioral health problems. This intervention is most effective for those with lower level of acuity in their behavioral health diagnosis. Rhode Island will encourage screening and referral through the leverage of requiring process and outcome measures as part of the payment transformation to value-based contracting. Screening measures including PHQ-9 and SBIRT do not require that a medical doctor for test administration, so this approach will not adversely impact the already heavy burden on primary care physician workflow. This is a significant step in integrating care and using care managers appropriately in a team-based approach to primary care.

- **Co-location Strategy #2: Co-locate Primary Care Providers at Community Mental Health Clinics.** Building on the successes of a number of community mental health organizations, Rhode Island recognizes that a crucial improvement tool to increase access to primary care for patients with behavioral health diagnoses is to bring primary care to the locations where populations who suffer from more acute needs are already located. This is a population is also likely suffering from chronic illness, and has a significantly shorter life expectancy as a result of many factors – but particularly due to lack of regular access to primary care (Merides, 2013). This is a patient-centric solution that acknowledges that such patients face many obstacles in their efforts to obtain basic health care, and by solving at least some of them, Rhode Island can improve their quality of life.

THE STATE WOULD WELCOME ADDITIONAL SUGGESTIONS FOR STRATEGIES TO ADDRESS RHODE ISLAND'S SIGNIFICANT BEHAVIORAL HEALTH AND SUBSTANCE ABUSE PROBLEMS

3. Patient Engagement:

A new value-based healthcare system requires dramatic changes in how people perceive their role and responsibility in maintaining their health. Currently, there are varying levels of health literacy in Rhode Island communities and people struggle to find and evaluate the quality of healthcare when they need it. According to stakeholder interviews conducted across the SIM Design process, citizens currently

perceive healthcare as a cost to their bottom lines, rather than a long-term investment in their quality of life. Across every level of patient engagement, the current system has low levels of transparency making it difficult for patients to evaluate appropriate cost and quality of their care. Employing new approaches to patient engagement, like information transparency combined with relevant education is therefore a top priority for Rhode Island.

Prior research (Health Affairs, 2013) has shown that improving patient and family engagement can boost clinical outcomes, reduce costs of care, increase the hospital's adherence to recommended strategies, improve patient satisfaction, and increase compliance with patient engagement requirements. The American Hospital Association recently released a report that included recommendations and a number of case studies of effective patient engagement strategies (American Hospital Association, 2013). Taken together, they illustrate the idea that individuals and families respond positively to increased information and skills when they are ready, are empowered by feeling as if they are members of their healthcare teams and feel successfully integrated with health care and health-oriented community organizations. In this light, Rhode Island will adopt the following additional strategies to increase patient engagement, and improve the overall health its citizens.

- **Encourage CurrentCare Enrollment -** Rhode Island will increase the awareness of and adoption of the statewide HIE system (CurrentCare). Due to long-standing concerns around information privacy, the General Assembly had dictated that the Health Information Exchange adopt an "opt-in" approach to enrollment. This has requires that each Rhode Islander have an awareness and understanding of its value in order to opt into the information exchange. Enrollment currently stands at approximately 30% of eligible Rhode Islanders and while efforts are being made by many parties to increase enrollment, the state will continue to support and supplement efforts through the provision of incentives to providers for enrolling patients in CurrentCare. Additionally, Rhode Island will create a patient portal into CurrentCare that will allow citizens to store and access their own healthcare and prevention data in one safe location. The addition of a portal to support engagement is a necessary next step along this development path. This will help patients with their accountability for their managing their own healthcare.

- **Health Risk Assessments.** Using the Office of the Health Insurance Commissioner and other regulatory levers, Rhode Island will support the movement of payers and employers to require the completion of Personal Health Risk Assessments to help residents understand and address their risks of developing chronic and other health problems. This effort, when integrated with providers' EHR and patient portals, will also allow the delivery of timely health interventions or pre-visit preparation, both of which should increase citizen's health literacy and ability to be accountable in a manner that is manageable and not overwhelming.

- **Communication.** Rhode Island will leverage the integrated communications strategy developed by Rhode Island's Exchange, HealthSourceRI and the public health communication efforts led by the Department of Health. Building on lessons learned and best practices in Rhode Island, the state will ensure that all healthcare reform messaging is well coordinated among entities. Through the development of Public Service Announcements (PSA's) and the use of social media,

and other important channels, there will be fully coordinated (and appropriately translated) messaging to residents**.**

- **Navigators and a Systems Ombudsman**. This new value-based care system represents a significant change in structure and will therefore be unfamiliar to most patients and consumers. Building off of the anticipated successes of the HealthSourceRI navigator program, Rhode Island will make sure that there are accessible and knowledgeable support workers available to patients and consumers to assist them with their healthcare system needs. Additionally, an agency or entity will be identified to monitor the effectiveness and ease of navigation of the system, from the point of view of the patient, and work to identify areas that may need improvement. This Systems Ombudsman will take on that responsibility and ensure that areas of difficulty within the system are addressed.

4. Population Health/Health Disparity/Social Determinants of Health Innovations

Addressing the underlying social problems that are strong predictors and creators of poor health is a challenge that Rhode Island continues to address. While the state acknowledges that these types of interventions are difficult to measure and often require a long period of time to culminate in significant change, it also acknowledges that these types of changes are as important as any other described above. In attempts to address the ongoing concerns of health disparities and the social determinants of health, the following innovations have been identified:

- **Through planning, encourage the State, Cities and Towns to Understand Social Determinants of Health:** With increased emphasis on the importance of health prevention and patient engagement, and increased coordination within state government around health prevention issues, Rhode Island makes a commitment to ensure that the state, as well as its cities and towns, increases its awareness of the importance of population health as an outcome of sound planning efforts. This should increase the state's accountability for the health of its citizens when creating growth and development plans.
- **Create a sustainable, commonly available fund for prevention activities.** The state of Rhode Island will standardize its prevention and public health efforts through a statewide funding mechanism that would provide services to all Rhode Islanders regardless of coverage type. Services could include vaccination efforts and the development of projects designed to improve the health of a community such as tobacco cessation, obesity prevention, and disease-specific efforts. Rhode Island's base of community organizations will be further strengthened through these efforts.

GLOSSARY

Accountable Care Organization (ACO): A healthcare organization that ties doctor and/or hospital payments to quality outcomes and cost of care for a population that has been assigned to them. The ACO contracts with a group or groups of providers to deliver highly efficient and effective care to its patients. The organization is accountable to the population it cares for and the payers that pay it money to provide care. If care is provided at a lower cost, the providers may share in a portion of the savings but only if quality targets are also met.

"ACO-like structures": the title "Accountable Care Organization" or ACO refers to an organization that is recognized by the federal government (the Centers for Medicare and Medicaid Services or CMS) as one that meets the definition described above and as such are eligible to treat Medicare or Medicaid recipients. There are other types of organizations that are similar in structure and goals and may mirror the ACO exactly, but they may not be recognized by the federal government. These organizations may be referred to in a variety of ways, such as collaborative care, accountable care, or coordinated care businesses. Their requirements for business operations fall under state laws as opposed to a combination of state and federal regulations for the ACO.

Attributed population or Attribution: in health care, this term refers to the assignment of a provider, or providers, to service a population of patients based on where claims data indicate the provider a member has primarily used in the past. That provider is deemed to be responsible for the patient's costs and quality of care (regardless of which providers actually deliver that care) in exchange for payment.

Bundled Payments: There are a number of terms that may be used to describe a bundled payment: episode-based payment, case rate, global or packaged pricing, and so forth. Essentially, it refers to payment to a provider or group of providers for the expected cost for a clinically-defined episode of care for certain conditions or diagnoses. This may include inpatient, outpatient or any other services rendered to treat the condition of the patient. The team of providers involved in the episode of care receive one lump sum for all needed care while individually they are paid fee-for-service for the care they deliver. As such, they are responsible for coordinating treatment within the prescribed budget while meeting or exceeding quality metrics.

Clinical integration: a network of doctors working (most often) in collaboration with hospitals. It includes a program of initiatives to improve the quality and efficiency of patient care, developed and managed by physicians, and supported by a performance management infrastructure. Clinical integration provides a legal basis for collective negotiation by independent physicians for improved reimbursement based on achieving better clinical outcomes and efficiency.

Community Health Teams (CHT): a coordinated team of often non-traditional care providers that interact or are integrated with traditional care teams like doctors, hospitals and long term care organizations. The CHT may include a nurse coordinator, social workers, dieticians, community health workers and care coordinators, or public health prevention specialists. As such, social determinants of health like housing, a person's sense of security, access to education, availability of healthy foods, and so forth can also be addressed in addition to more traditional physical and mental health. Operations are often supported by centralized technology systems that can "talk to each other" and share critical health information among the team such as electronic medical records, provider directories, and tools for predictive modeling of the health of the population served. CHTs work well when integrated with patient centered medical homes, provider groups, and accountable care-type organizations.

Patient Centered Medical Home (PCMH) or Medical Home: A model of care that emphasizes care coordination and communication among providers. There are five functions of a PCMH: 1) it is patient centered meaning care is individualized and reflective of patient needs, culture, values and preferences; 2) care is comprehensive which means the organization is accountable to deliver a large portion of what its population needs like physical and mental health care needs, including prevention and wellness, acute care, and chronic care; 3) coordinated care means that the PCMH is responsible to the patient to ensure all aspects of their care and their providers are working toward the same goal, the patient's health. This may include hospital, outpatient or community services; 4) access to care means that patients are able to be seen when needed, experience shorter waiting times for urgent needs, around-the-clock telephone or electronic access to the care team; and 5) quality and safety are assured through the use of medicine and treatment that is "evidence-based" meaning there is clinical evidence for its effectiveness. PCMHs use systems-based tools to help in the measurement and reporting of the effectiveness of care including patient experience and satisfaction.

Risk: Today there is much discussion about doctors and hospitals "taking on risk." This means that a provider (a doctor or hospital) agrees to be responsible for the quality and cost of some or all of the care delivered to a set of patients. The risk they assume may be "assigned" to them through a contract with a payer like an insurance company or an employer. The contract may be as simple as receiving a bonus for improved quality. These arrangements are often referred to as pay-for-performance and are designed where a portion of the provider's payment is withheld or tied to performance based on process or outcome measures that are pre-determined. Some forms of risk payments may also include Bundled Payments; an arrangement where a group of providers are paid a lump sum to treat a specific condition from beginning to end, regardless of the care setting. Providers must collaborate to improve quality and reduce costs in order to receive the bundled payment. A shared-savings model is one where providers are paid a negotiated fee for their services but held responsible for the total expense for a given patient population through comparison to a benchmark or budget, e.g., the cost of care for the same population in the previous year. Providers share in savings but are not at risk for losses. Finally, capitation is a payment method that pays providers on a set amount for every member of the population they are responsible for. The payment is made on a "per member, per month" or PMPM basis. The provider in this instance is responsible for both upside (savings) and downside (losses) risk.

Shared Savings: at least part of a provider's income is directly linked to quality and the financial performance of a health plan. If costs for a specific population are lower than projected and quality is at the same level or better, a percentage of the savings is paid to the providers.

Transparency: in health care, this term refers to the sharing, publicly, of cost and quality information. It is meant to 1) provide doctors and hospitals with benchmarks for improving their performance, 2) encourage consumers and payers to reward quality and efficiency by purchasing from those organizations with the highest quality and lowest cost, and 3) to help consumers make informed decisions about their health care purchases. It is NOT the sharing of individual or personal patient information but rather an aggregation of severity-adjusted cost and quality information of a treatment or condition by provider, geographic area, or by other demographic data. For "value-based purchasing," both quality and price information are essential to know in order to compare and make decisions. Transparency of cost and quality information has become more important as the cost burden has begun to shift to the consumer in the form of high deductibles, co-insurance or full fee-for-service in the case of the uninsured.

Value based care or purchasing: In contrast to the prevalent "fee-for-service" system of provider payment, value-based purchasing and care rewards the provider for delivering high quality, efficient care that is safe and at a low cost. Rewards, bonus payments, or shared savings to providers are conditional on achieving pre-determined goals for quality and cost. The financial incentives are designed to discourage inappropriate, unnecessary, or costly care when other equally acceptable alternatives are available.

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